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ABSTRACT

The report on programs and needs of mentally ill and handicapped children, especially in the District of Columbia, contains 10 statements, 22 materials submitted for the record, and 29 appended articles and studies. The purpose of the hearing is stated to be that of hearing testimony from the people of the District of Columbia in connection with the mental health work and programs for the handicapped in the nation's capital. The chairman notes that the District is doing a commendable job, but that the government needs to spend 10 times as much money as it is currently doing to serve the mentally ill and handicapped. The need for residential facilities and residential psychiatric treatment programs is emphasized. Materials submitted also focus on the need for residential facilities and programs, early childhood education, and special classes. The majority of the report consists of the appended articles and studies. Selected appended articles and studies include the report of the Joint Commission on Mental Health of Children, residential treatment centers for emotionally disturbed children, adolescent patients served in out-patient psychiatric clinics, civil action suit in U. S. district court, a proposed model law on special education, and state law and education of handicapped children. (CB)

MENTALLY ILL AND HANDICAPPED CHILDREN

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HEARING

BEFORE THE

COMMITTEE ON THE DISTRICT OF COLUMBIA HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

SECOND SESSION

ON

SUMMARIZING THE PROGRAMS AND NEEDS FOR MENTALLY ILL CHILDREN, SPECIAL EDUCATION FOR HANDICAPPED CHILDREN, AND EARLY CHILDHOOD EDUCATION IN THE DISTRICT OF COLUMBIA

MARCH 14, 1972

Printed for the use of the
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DISTRICT OF COLUMBIA MENTALLY ILL AND HANDICAPPED CHILDREN

TUESDAY, MARCH 14, 1972

House of Representatives,
Committee on the District of Columbia,
Washington, D.C.

The Committee met, pursuant to notice, at 10:40 a.m., in Room 1310, Longworth House Office Building, the Honorable John L. McMillan (Chairman) presiding.

Present: Representatives McMillan, Abernethy, Smith, and McKinney.

Also Present: James T. Clark, Clerk; Hayden S. Garber, Counsel; and Leonard O. Hilder, Legislative Assistant.

Mr. McMillan. The purpose of this hearing is to hear testimony from people of the District of Columbia in connection with the mental health work and programs for the handicapped here in the Nation's Capital. From all the information I have been able to receive, you people here in the Nation's Capital have been doing wonderful work and especially the volunteers who are interested in this most important problem confronting not only the people here in the Nation's Capital, but throughout the United States.

All the news I have received through substantial and reliable citizens of Washington is certainly a credit to you people who are here to give testimony on this subject today. I want you to know that I am a great believer in giving every assistance possible to the unfortunately retarded and handicapped.

We should spend ten times the amount we are spending in the United States at the present time in an effort to give these unfortunate children some relief and assistance.

Mr. Cecil Camlin, who assisted in arranging this hearing, is from the State of South Carolina, and he can vouch for the fact that we are struggling with this problem in our state.

I think we are doing an excellent job; however, we all know we are approximately fifty years behind in recognizing and giving financial and other support to solve this problem.

Mr. Camlin.

STATEMENT OF CECIL M. CAMLIN, JR., EXECUTIVE DIRECTOR, SOUTH CAROLINA MENTAL HEALTH ASSOCIATION; MRS. STANLEY BREGMAN, FORMER CHAIRMAN, PUBLIC AFFAIRS COMMITTEE, D.C. MENTAL HEALTH ASSOCIATION; WILLIAM E. FOWLER, JR., PRESIDENT, D.C. MENTAL HEALTH ASSOCIATION; MRS. GERALDINE DAVIS; DR. JOHN L. JOHNSON, ASSOCIATE SUPERINTENDENT, SPECIAL EDUCATION PROGRAMMING, D.C. PUBLIC SCHOOLS; DR. REGINALD LOURIE, CHAIRMAN OF THE

DEPARTMENT OF PSYCHIATRY, CHILDREN'S HOSPITAL, AND CHAIRMAN OF THE JOINT COMMITTEE ON THE MENTAL HEALTH OF CHILDREN; DR. EVA TOWNS, CHAIRMAN OF THE PROFESSIONAL ADVISORY BOARD OF THE ASSOCIATION; DR. JULIETTE M. SIMMONS AND MRS. ROBERT MARTIN, CO-CHAIRMAN, PUBLIC AFFAIRS COMMITTEE, D.C. MENTAL HEALTH ASSOCIATION; AND DR. ESSEX C. NOEL, DIRECTOR, D.C. MENTAL HEALTH ADMINISTRATION

Mr. CAMLIN. Mr. Chairman and members of the District Committee, thank you for this opportunity. I am Cecil M. Camlin, Jr., the Executive Director of the South Carolina Mental Health Association, and a member of the Public Affairs Committee of the National Association for Mental Health.

The reason we are here today is the needs of mentally ill children. Mentally ill children know no geography, no social level, no race, and while we have this problem acutely in South Carolina, you have it here, and it is with this thought that I now introduce Mr. William E. Fowler, Jr., the President of the District of Columbia Mental Health Association.

Mr. McMILLAN. Thank you and at this time, I would like to state that we are real proud of the work Mr. Camlin is doing in South Carolina. I'm certainly happy that I was one of the first members of Congress to introduce a bill try to assist with the children's mental problems we have confronting us.

Ten or fifteen years ago, I introduced one of the first bills on this subject. I think we're 50 years behind in solving the problem. We need to catch up on an awful lot of work, and I'm supporting this group group 100 percent.

Mr. CAMLIN. Thank you, Mr. Chairman.

Mr. McMILLAN. The Committee will be glad to hear any statement you wish to make.

Mr. FOWLER. Thank you, Mr. Chairman, members of the Committee. The District of Columbia Mental Health Association is deeply appreciative of your taking time from your busy schedule to grant us this audience this morning. As you are doubtlessly aware, the District of Columbia Mental Health Association is a group of volunteer citizens who were incorporated in 1953. We are an affiliate of the National Association of Mental Health, and we are a United Givers Fund Agency. We have a board of directors which is comprised of 38 persons, citizens from the District, and we feel that they are truly representative of this metropolitan area. They came from all sections of the city, the better sections and the inner sections as well, black and white, Jew and gentile, all in direct proportion to the membership of the D.C. Mental Health Association.

And of course, the main goals of our Association are to prevent mental illness and the promotion of mental health, but we try to do this and execute our programs the means of education, social action, and services.

While we are involved in enumerable programs, I would just like to elucidate a few. We are engaged currently in social work, in community service, to over 200 former mental patients who are now living in foster homes. We are finding jobs for former mental patients under a program we describe as our pinch-hitters' program, and we have met with a great degree of success with out pinch-hitters' program. Of course, we've always been engaged with voluntary services in St. Elizabeths Hospital. We engage in public education; we promote mental health through high school students. We have a youth council which is comprised of at least two to four high school students from every school in the Metropolitan Washington Area, be it private or public.

We give assistance to public and private agencies in planning mental health programs. We monitor public budgets, laws, and administrative procedures affecting the mentally ill and their families, and we study the amount and quality of services and the desemination of facts.

Now, we have several demonstration projects currently in action, but the one that we are most proud of is a project that we are engaged in in conjunction with Catholic University that we entered upon last September, where we have taken ten foster children, together with their parents and they are attending classes at Catholic University every afternoon.

This involves not only education and treatment of children, but for the parents as well.

I think it would be well at this time if I introduce my associates here at the table, Mr. Chairman, and members of the Committee. This is Dr. Juliette Simmons, who is a noted psychiatrist in the field of mental health and co-chairman of our public affairs committee, and of course Cecil Camlin you know, and this is Sandra Bregman, who will be making the principal presentation to you this morning, and Mrs. Geraldine Davis, whom you will hear from in a few moments, and Dr. Eva Towns, who is another renowned psychiatrist in the field of child mental development, and Mrs. Robert Martin, who is co-chairman of our public affairs committee.

I might add that Dr. Simmons and Mrs. Martin are primarily responsible for our being here today and for everything that you will listen to, because they and their committee have worked quite arduously for the presentation that you will hear very shortly.

We hope you will find our presentation interesting. We hope you will find it worthwhile, and we certainly hope that the Committee will see fit to respond to it.

So, without further ado, Mr. Chairman, I would like to introduce our spokeslady, I should say, who will make our main presentation this morning, Mrs. Sandra Bregman.

Mr. McMillan. Thank you very much. I can assure you that every member of this Committee is very much interested in this subject and you will have our full cooperation.

Mr. Fowler. Thank you, Mr. Chairman.

Mrs. Bregman. I am Sandra Bregman.

Mr. Chairman, first of all, I would like to thank you again for giving us this opportunity to come here and tell you about the plight of the mentally ill child in the city of Washington. We, as the Mental Health Association, speaking for all those who are presently mentally ill and those who might become mentally ill if the proper services are not available to them, but this morning we would like to specifically speak about the children and their needs, because that is where the need is the most acute and that is where the hope for change is the greatest.

There are thousands of children in the District of Columbia who are mentally ill and yet there is no public residential treatment facility for these children. There are fewer than 60 beds in the entire public sector, including St. Elizabeths.

What we need, specifically, Mr. Chairman, are three things—first of all, we need the creation of a system of four comprehensive care residential centers for mentally ill children and adolescents to be placed in the four mental health areas of the city.

Secondly, we need to enact a mandatory special education law for handicapped children.

Third, we need to create a system of early childhood education. This need is especially most acute for those children who live in foster homes.

I would like to state, Sir, that we speak only for the citizens. We do not speak for the City Government, nor for the Mental Health Administration. We have done everything that we could think of as a Mental Health Association to bring the attention of the public, of the citizenry, of the press to the plight of the mentally ill child in Washington, but we have had few results.

That's why it's necessary for us to come to you. There are 30,000 children in the city of Washington who are mentally ill. These figures were arrived at by using the figures in the Joint Commission Report on the Mental Health of Children, a study that was created by an act of Congress, and was published in 1969. By using the figures they projected and projecting them onto the population of children in the District of Columbia, the Mental Health Administration has arrived at this figure. We don't have the names and addresses of these children, but we do know they are there and both demographers at NIMH and the Mental Health Administration said this indeed is a conservative estimate.

If we just look at the figures of the Social Rehabilitation Administration, we find an estimated 14,000 children with serious emotional problems, and this does not count the children who have never come into contact with the Social Rehabilitation Administration.

I would like to stop for a brief moment and define the difference between mental retardation and emotional illness. When we use the phrase mentally retarded, we refer to sub-average general intellectual functioning which originates during the developmental period, prenatal or post-natal.

On the other hand, an emotionally disturbed child is one who cannot cope with his life. His personality development has been impaired and interfered with. It has been stopped by factors in his environment. He seems immature for his age and his intellectual endowment, which is frequently very high. He cannot interact in an acceptable way with his peers. Sometimes he has temper tantrums and crying fits. Some get down on all fours and think they are a dog. Others cannot relate with any human being and they withdraw inside of a shell and they cannot learn, they cannot control their impulses.

Those who are most severely depressed try to kill themselves.

I will never forget a meeting, Mr. Chairman, last spring, one of our committee meetings at the Mental Health Association, when a member of the Public Education Department came in and sat down and took her seat, and she said, "I hate to see spring come. We have so many suicide attempts in the schools each spring".

When we speak of mentally ill children, there's a vast range of severity in describing their condition and their needs, and that is why we need a vast range of treatment available for them. One thing is certain—when a child becomes mentally ill, if he is not helped soon, then he can only get worse.

I would like to tell you about some of the calls for help we have received at the Mental Health Association, calls which leave us depressed and frustrated because there's really nothing we can recommend. There's no place for these children.

We had a school counselor call asking for help. She had a bright but uncontrollable sixth-grade girl who brought a pocket knife to school and threatened the other children. Did we know of a residential treatment facility she could put the child in? Two of our board members witnessed a thirteen-year-old girl screaming and banging the walls at the detention room at Juvenile Court for 45 minutes. At 5:00 p.m., when the Judge returned, the ladies asked him what was wrong with the child and he replied, "She's obviously psychotic." They said, "What will happen to you?" He said, "Well, she'll go back to the receiving home, and if anyone is there to help her, they'll probably give her a tranquilizer."

A private psychiatrist tells us that she's keeping four of her patients in her own home with her own children because there are no appropriate facilities for them, and she will not send them back to their homes, which is the primary cause of their illness.

The wife of a United States Congressman, an Urban Service Corps Public School volunteer, called asking us to recommend a treatment facility for a seriously disturbed 14-year-old girl. She talks and talks and walks around the town looking for her mother. who deserted her, or she sets herself up in closets. She will not stay in a classroom; she has no money.

We hear hundreds of cases like these each year, and there is nothing we can recommend because there is no place in the city of Washington. The most serious gap in the treatment facilities available within the public domain is the total lack of any residential treatment facility. And we have less than 60 hospital beds. There are seven fine private facilities. These private facilities have a total capacity of 300 beds. The cost ranges from $11,000 per child per year to $36,500 per child per year.

It's obvious that only an affluent family could afford to send the child to one of these institutions and even then, the waiting lists are tremendously long.

The Mental Health Administration operates two day-care centers which care for 44 children. They also have a therapeutic nursery caring for 17 children.

But what does all of this add up to when we have a least 14,000 children seriously ill within the Social Rehabilitation Services alone? Not much at all, as you can see.

Our Association was so distressed by the lack of treatment facilities that last year our children and adolescents committee did a very serious study of what was available in both the public and the private sector.

Gentlemen, you will find it in your appendix, and it shows you what does exist and also what does not exist. We are now sending 505 children at the cost of $1,300,000 to facilities, some as far away as

Texas, for treatment, and we have a waiting list of 398 children waiting for that kind of treatment.

Perhaps you're wondering what kind of facility I am proposing. Working through a task force, including the D.C. Mental Health Association, the Mental Health Administration has put together a task force which has designed a plan for four comprehensive care residential treatment centers. Each one of these four centers would treat 100 children on a daily basis; 80 of them would receive day-care and there would be residential facilities for 20 of the 100.

When we speak of residential treatment, we're talking about what is called in the profession a therapeutic milieu. We are talking about a daily pattern of living which will be corrected and which will help these children learn how to interact in an acceptable way with their peers, with their parents, with their teachers, with figures of authority.

There will be individual therapy and group therapy, education and play therapy. It will also be important at these facilities that these facilities be located in the neighborhood that the child is in because it's very important to bring his parents in for counseling.

It's very important that when he begins to get well enough, that he can return to the outside world, that he be near his local public school so he can return to his local school classes in the day and perhaps come back at night if that's necessary.

There will be a vast variety of programs available, tailored to the needs of the children and the particular severity of their illness.

Obviously, such treatment is expensive, In our local private institutions, as I have said, the cost ranges from $11,000 per child per year to $36,000 per child per year.

In the State of Massachusetts, where all children have been, by law, deinstitutionalized, residential treatment averages $7,000 per child per year. The cost of providing residential treatment service at the Episcopal Church Home for Children In York, South Carolina, is $9,000 per child.

Mr. Howie, the Executive Director of the Episcopal Church Home, has stated: "Without residential treatment, these children would spend their adult lives in institutions".

And Senator Waddell from South Carolina has estimated the cost of keeping a child institutionalized for his life expectancy at $1 million for six children.

But even more important than this, how can we measure the cost of salvaging a human life? The 92d Congress has already appropriated capital outlay funds to renovate or construct tow of these comprehensive care residential treatment facilities and the amount of $600,000 was appropriated for program money for this year.

What we are asking here today is that instead of two, that some time soon we would need four, one in each health area of the District. We are requesting, therefore, an additional capital outlay of $1.5 million and the yearly operating cost of running these four residential treatment facilities would run $4 million.

These figures are high. The benefits are incredibly higher. We would all agree, I think, that it is impossible to place a pricetag on the saving of a human life, but we are also aware that Congress understandably wants to know what it's buying for every public dollar.

Accordingly, if we assume—and this is a conservative estimate—that these centers will treat 400 children each every year, and that perhaps half of these children will never, because of this treatment, have to undergo institutionalization, then, applying Senator Waddell's figure for the lifetime lockup, we would be saving $135 million for an annual expenditure of $4 million on the four centers. This works out to a savings of a $50 return on every $2 invested. I wonder, would any of us hesitate to make that kind of an investment with our own money, let alone the public's?

Secondly, I would like to turn your attention to special education. Because residential treatment is so expensive, because it is also expensive in terms of what it does to the children—in other words, if you let a child become so ill that he must be put in a residential treatment facility, then it's already very, very late in the game.

What we ought to be doing is helping these children when they're very young, when they're 3, 4, 5 or 6, and therefore, we turn to the public schools, to the Department of Special Education.

When we think of the Department of Special Education, we in the Mental Health Association speak for all children. First of all, we speak for those who are already mentally ill and we believe that they must not be denied their right to a free public education.

Secondly, we speak for children who are otherwise handicapped—the blind, the deaf, those suffering from dyslexia, from neuro-muscular diseases. These children run a very high risk of also becoming emotionally disturbed if they do not receive the right kind of education tailored to fit their needs.

In the city of Washington, the system works this way: when a child is noticed by his teacher, when he acts out in class, when he disrupts the classroom, the teacher decides that perhaps he needs help and she refers him to the Department of Pupil Personnel for testing. Then begins the long wait. Sometimes after the child is referred for testing, it's anywhere from 6 to 9 months before the child is actually tested.

Finally, he is tested and if he is diagnosed as needing special education, the really long wait begins. We have had mothers tell us that three years after they were told their child needed special education, they were still waiting for that child to be placed in a special education class. And when this happens, everyone loses because when children who are ill disrupt the classroom, the children who are well can't learn either and everyone loses.

As of September 27, 1971, 1,501 children were on the waiting list for special education. They are still on that waiting list today.

When we deny these children their right to an education, we are denying them their future. We are literally giving up on them. To serve these children who have been identified, for whom we do have names and addresses, would cost $3.5 million, in addition to what is currently in the 1972 budget.

The United States Office of Education, however, has estimated that there are 18,000 children in the District of Columbia who require special education services. To provide services for all of these children would cost in the neighborhood of $40 million.

We do believe, however, that there must immediately be money made available to put the 1,501 children who have been identified in the necessary special education classes.

What we really need, sir, is a mandatory special education act for handicapped children. The reason why law is so important, I believe, is that it evidences written public policy to recognize a social ill and to deal with it.

In my formal testimony, you will see the things stipulated that I believe should be in that kind of a law, but the three most important things I would like to point out—first of all, we would like to have a law require mandatory education for the exceptional child. Secondly, establish procedures for identification and placement of the child and ensure due process for the child and his family. And the other, most important factor and the most important reason for having this law, is that when money is appropriated for special education, is must be held sacred, if you will. It must not be diverged or merged into the rest of the school budget. This money must be absolutely inviolable. It must be there for the needs of exceptional children.

I would like to point out, Mr. Chairman, that your State of South Carolina has shown leadership in this area and six weeks ago your state wrote into law a mandatory special education act. You also, by the way, have one of the finest residential treatment facilities in the country, the William S. Hall Institute. That's the kind of institution, kind of facility, we need here.

Again, our cost analysis more than justifies our request for $3.5 million so we can handle an additional 1,500 children. If even 25% of those children would other wise have to be institutionalized in their lifetime, we would save $64 million, a return of close to 20 to 1.

Our third request, sir, is for the creation of a system of early childhood education, early childhood intervention, most urgently needed by those children who live in foster homes. When a child is put in a foster home, it is always for a terribly unhappy reason. Perhaps his parents are in jail. Perhaps his parents are ill. Perhaps they are mentally ill or perhaps it is just simple poverty.

Nevertheless, when a child is put in a foster home, it is a tremendous trauma in his life. In the city of Washington, there are 500 children under the age of six living in foster homes. Frequently children under the age of six are shifted from one home to another, causing more and more traumas to pile up.

Knowing this, five years ago in the Mental Health Association, our experts went to work on a proposed Child Learning Center which would be specifically geared and tailored to meet the needs of these children who live in foster homes. We raised the money for this Child Learning Center through our annual benefit and we opened the doors last September and it is the only place of its kind in the United States. It is the only therapeutic nursery specifically established for children in foster homes.

Now, we know that putting these children in homes, rather than a large institution, saves a great deal of money. We would like to see some of that money used to be supportive of the foster parents. We would like to see therapeutic nurseries established throughout the city specifically for those children in foster homes, and hopefully, eventually for all the children who need them. But we believe the need is most urgent for those children in foster homes.

At Catholic University, it is costing us approximately $2,000 per child per year. This is high because the facility is very small, the physical facility is small. We believe the city could establish a system of nursery schools for foster children for perhaps $1,500 per child, perhaps following our model, perhaps another model altogether, but we feel that this should take place very urgently.

In summary, then, the three requests we make of this Committee today are that it act favorably upon legislation affecting 30,000 or more children. We ask you to authorize (1), the creation of a system for comprehensive care residential centers for mentally ill children and adolescents to be placed in the four mental health areas of the city; (2) to enact a mandatory special education act for handicapped children; (3) to create a system of early childhood education facilities, especially for children in foster homes.

If we go home today failing to have moved you, we or some other citizen group will be back in a couple of years. By then, the need will be much greater. By then the costs will be much greater. The costs to society will be horrendous. Wasted lives, unfulfilled human potential. There will be more children on drugs, more children dropping out of school, more children committing crimes. Continued neglect of these children can only mean continuation of crime, violence, disrupted classrooms, and innumerable unproductive lives.

If we stopped for a minute to think about the child who cannot cope with his life and no one helps him, and he grows into manhood and he still cannot cope with his life, nor can he cope with a job, nor can he cope with a marriage or children.

This kind of child will grow up to be an adult who uses alcohol or drugs, who probably won't be able to hold a job, and who will eventually be on welfare. Think for a minute of another type of child, the type of child who is violent in his classroom, who is hostile to his teacher, hostile towards his peers, hostile towards his parents. Eventually, this child gets in trouble with the law. He begins the long trek through the juvenile courts. He ends up at Laurel, and each step along the way, he becomes a more refined criminal.

Take a third example, a child who is withdrawn, has pulled himself inside of a shell, who cannot relate to human beings around him. If this child is not helped, he will grow up to be an adult inmate of St. Elizabeths.

The alternatives are clear. Either we provide residential treatment facilities, special education classes, early childhood intervention services, or we will have more drop-outs, more drugs, more violence, more assaults, more rapes. We will have to build more Laurels, more Lortons, more St. Elizabeths.

Surely the people of this country would rather spend their tax dollars to build and to heal a human personality, to provide the educational services that would allow each child to reach his greatest human potential whether that is great or whether that is small. Surely, our people would rather do this with their tax money than building more jails and more state mental hospitals. I know this testimony is depressing. So is reading the newspapers every day. Many of our children, as I stand here this morning, are out of school because they are emotionally ill. And yet, they go untreated.

Hundreds more are finding their way to juvenile court or to Laurel, something which could have been prevented if these services had been available a few years ago. The need is so obvious. We know how to help these children. We know how to rehabilitate them. What we need from you is the commitment to fill these glaring gaps in services for these children who need it so desperately. Mr. Chairman, I would like to ask the mother of a child who is mentally ill—this mother has gone through the frustrations of caring very deeply about her child and not being able to find the appropriate services for her child. I would like to present Mrs. Clarence Davis.

Mr. McMillan. We will be happy to hear from you.

Mrs. Davis. Mr. Chairman, my plight takes about seven years of experience, so I will be as brief as possible. I discovered my child was slow in talking, which didn't bother me too much. But, when I took him to the pediatrician, he suggested that I take him to another doctor and he spent about five minutes with me that morning and said, "Your child is mentally retarded." Well, it didn't strike me until I got in the lobby. I got home and I called him, and I said, "I hate to dispute your professional abilities, but I disagree with you because, I am looking at him, I lived with him and I do not see any mental retardation."

So he preferred not to talk to me and sent me to Gale's. When I got to Gale's, and they did all of the regular intake stuff that they do, and they said, "Well, he is retarded. But, you know, he can be taught."

But the child is reading now, at three years old.

So, the lady sent off the necessary material. And, I was not being facetious. I told them, I said "I don't understand this." You know he had to be—like if he had to put his clothes on and feed him and all this. This is for that type of child. And, she said, "Well, Mrs. Davis. This is all we have. I can send you to a D.C. recreation preschool. Well, I went there. And the parents of the community, you know, pay them a certain amount of money for their children to go."

So, since this is a parent thing, the parents decided, well if he is mentally retarded, then we don't want him in with our children. Well, a teacher there seemed to be very concerned and she sent me to something like a private day care center. And, we got there, and the first week, he was busy. He was a hyperactive child. And, he was busy that week. But, after that one week, the business calmed down.

But, one day I went to pick him up. I had to take him to school at 8:00 o'clock in the morning, pick him up and 12:00. So, that meant I had to take him, catch the bus back home, catch the bus back to pick him up, and catch the bus to bring him back home. And, I had two other children.

Well, I did that. And, then, I got there one morning and the lady had him sitting on the corner. Now, he had been labeled very good by this time. And, I said, "Where is Chris?" And, she said, "Oh, he is in the office." And I became upset, because he had been doing O.K. So, I picked him up, and took him home. And, I didn't take him back. But, she also became concerned and she sent me, I guess, to a mental health facility which is in Georgetown. And I went there and they said, "Chris is emotionally disturbed." Well, that sounded better to me as a parent than mentally retarded.

But in order for you to get help for him, you know, you have to relinquish custody. So not knowing what "relinquish" meant, I asked her. And she said, to assure these schools that they would get the money, you have to sign him over to the D.C. government. Well, you see, he wasn't old enough to go to school anyway. And, I didn't want to do that. So I waited.

Then, he became—he came to school age and so then he needed mental help and was in special education. And, I was very truthful with them. I told them what had been recommended to me and what to do.

Go ahead, Mrs. Davis, enroll him in school, and if any problems come up there, we will take it from there.

Boom. Well, the problem came up, the first five days of school. He went to school five days and was five years old and I called Special Education and told them, and they in turn sent out a psychologist and a social worker. All of these people. Because they weren't giving me anything.

Well, they came out, and I was taught to be obedient, so I followed the schedule. The psychologist was supposed to test him for five days. And, I went with my child for five days and I never saw her until the last day. But by him being labelled from the ghetto, then the school didn't want him either.

So, the second child in my family, it was time for him to go to school. So, here you have one going to school, and the oldest staying home. So, I had to accept what I did not want, which was residential treatment, giving up the custody of my child. We went down to Welfare, and applied for the money and it was granted after a lot of things.

Then, we got a summons, because—we are husband and wife but we have two individual summons. We attended the court, and the judge said because you don't have the money, which all it amounts to really is that the child has this problem, and it makes the parents think that they are unfit. Well, they fix it awfully pretty for you, you know, because you have to take this. You have nothing else in the District.

Well, the child was sent to Rockville, and the child was helped tremendously. But then, the other mental problem was coming, and they weren't helping us. They were then setting the parents up for these people here. So we decided that we would take him out.

In order to take him out, we had to have something definite because they wanted to send him to Texas and we recognized that we didn't have the money to get out there to see him. The District had him in their custody, so what could we do? There was nothing we could do.

I put him in public school, and he stayed in public school until about three or four weeks ago. He stayed there from September 13 to January 1. I went back to Special Education and they give you the run around.

Well, I thought he was still there. I don't know where this is. Well, this parent did this, and this parent did the other. I got the yellow pages and I called the Information Center, Handicapped, whatever it is, and I got a Mrs. Yetta Galiber on the phone. And, she said, well I had talked to her all over the summer, and she said go to Special Education.

And, I said, if you don't help me, I am coming down there and I am going to choke you, to get some kind of help. Well, the principal wrote letters back and forth to Special Education and Mrs. Davis, we will call you. From this day, from the 28th of January until this day, I have not heard from Special Education, but they did send me a letter saying O.K. we have tuition money.

He is in a private day school where he can go and come, but yet I still have the custody of him.

Mr. McMILLAN. Thank you very much.

Mr. ABERNETHY. Mr. Chairman, I have to leave a little early. May I ask the lady a question?

Mrs. Bregman, you made a very interesting and exceedingly moving statement. I am sure that the other members of the Committee who heard your statement are impressed. And, I am particularly impressed with your knowledge of this subject and the time and effort that you have put into it.

You made certain recommendations. In order to interpret the recommendations correctly first let me inquire of you further about them. Does the District Government now have the authority to do the things which you have recommended? Does it have the legal authority to move on the three recommendations that you make?

Mrs. BREGMAN. Well, in the case of the first recommendation, the creation of the four residential treatment facilities, the money was appropriated for the construction of two of them last spring, and plans are currently going ahead to construct those two facilities.

Mr. ABERNETHY. If I may interrupt you, then, we must assume that they have the authority to fill your first recommendation.

Mrs. BREGMAN. Yes.

Mr. ABERNETHY. So, fulfilling the remainder of it is out of our hands. It is now under the District government. Is that not right?

Mrs. BREGMAN. With the exception of the fact that the money would have to be appropriated.

Mr. ABERNETHY. This committee does not handle that. That is handled by the Appropriations Committee. Now, has the District government budgeted money sufficiently adequate to fulfill the recommendation you have made, that is, recommendation number one?

Mrs. BREGMAN. For two facilities. The amount for the program money.

Mr. ABERNETHY. Now, when did they budget money for the two centers.

Mrs. BREGMAN. The two centers—that was in—the bill was finished in December, just before the close of the last session.

Mr. ABERNETHY. That was for Fiscal Year '72?

Mrs. BREGMAN. Yes.

Mr. ABERNETHY. Now, are there funds budgeted for Fiscal '73 for the other two centers?

Mrs. BREGMAN. No, there are not.

Mr. ABERNETHY. Did you ask the District authorities to include such—you or others interested in this subject?

Mr. FOWLER. We were informed that such funds would not be forthcoming. We have been in constant touch.

Mr. ABERNETHY. I don't think that is quite my question. Did they consider budgeting funds for that purpose?

Mr. FOWLER. No.

Mr. ABERNETHY. Did they say that the budgeting would not be forthcoming or that the money would not be forthcoming?

Mr. FOWLER. They just didn't have the money. It had not been appropriated as of that time.

Mr. ABERNETHY. Is the money available for appropriation?

Mr. FOWLER. To the best of our knowledge, it is not.

Mr. Abernethy. Now, the enactment of a mandatory special education law—has there been any legislative move made in that direction? Is that now the law, or is it not?

Mrs. Bregman. No, it is not, sir. We have a digest to follow the special education acts and that is not the case.

Mr. Abernethy. Does the Department of Education of the District of Columbia concur with you that there should be such a law?

Mrs. Bregman. Yes sir, a Dr. John L. Johnson is here with us today.

Mr. Abernethy. Does the District government concur?

Mr. Fowler. To the best of our knowledge, they do. We have Dr. Essex C. Noel in the audience who's been working actively on this problem and I am sure he has addressed himself to it.

Mr. Abernethy. Well, that answers my question. Does the City Council have the authority to enact such, or does that require a Congressional Act?

Mrs. Bregman. I believe it would require a Congressional Act.

Mr. Abernethy. Have you checked it out?

Mrs. Bregman. I believe our legal counsel did check that out and it would require Congressional action.

Mr. Abernethy. Would you please check it again? You seem a little hesitant about it.

Mrs. Bregman. We certainly will.

Mr. Abernethy. Now to number three. You recommend the creation of a system of early childhood education facilities, including children in foster homes. Does that require a legislative act of Congress, or simply a move by the Board of Education or the City Council?

Mr. Fowler. The City Council and the Board of Education, sir.

Mr. Abernethy. You know, the Commissioner, who is often referred to in the District as the Mayor, has—and I'm not shifting the responsibility to him—don't misunderstand me: he has a tremendous amount of power. It is almost a one-man government. He has the authority to create or abolish, as I understand, commissions within the District of Columbia. That is the way I recall the law, passed a few years ago moving from the three commission form of government to a one man commissioner form of government with a Council which is more or less advisory.

Now, I don't know whether the Mayor has the authority to do this or not, but—or the City Council—but I do think that someone should check on that and let us know. And, if not and if such is in existence, well I am sure that there is somebody on this hill who would be interested in introducing legislation designed to go forward. I am not saying that it will become law, I am just saying that you will have your day in court in this Congress.

And, again, I want to commend you, Mrs. Bregman, for your statement. And, Mrs. Davis also. Thank you Mr. Chairman.

Mr. McMillan. Also, Mrs. Bregman, I think you made one of the most informative statements here this morning that I have heard before this committee since I have been Chairman. You have gone into this matter thoroughly, and you seem to know exactly what you are talking about. We have had the same trouble in South Carolina. And we took the bull by the horn and we are really doing something about it. I am sure if we have you ladies behind us we can do most anything.

Dr. Simmons. I would like to address myself to Mr. Abernethy. In conjunction with the collaborative collection of data that we presented today, we did discern that the $1.2 million that was allocated for the two centers had been deleted from the budget to indicate their degree of sensitivity to that need.

Mr. Abernethy. Who deleted it?

Dr. Simmons. I don't know how it was deleted, but it was deleted. And then, as a result of outside sources coming to the foreground and asking that it be re-inserted, it was re-inserted but it had been deleted. I do feel that that is an indication of the degree of sensitivity.

Mr. Abernethy. Let me see if I understand what you are saying. I assume that the Department of Education of the District made recommendation to the District government to include this item in the budget.

Dr. Simmons. Yes. It was made initially.

Mr. Abernethy. Now, did they actually include it? And then delete it? Or, did they fail to enter it?

Dr. Simmons. Sir, it was included and then was deleted. And, as part of the text that we have accumulated, we can send you that data.

Mr. Abernethy. Was it deleted before it was submitted to the Hill? It would have to be deleted before, and if it was, then it was never really budgeted.

Mr. Bregman. It was deleted and it was put back in after citizen pressure. It was in the budget that was presented to the Hill.

Mr. Abernethy. Are you speaking of something that happened at City Hall?

Mrs. Bregman. Yes.

Mr. Smith. Mr. Chairman, I just want to compliment the members of the District of Columbia Mental Health Association as a dedicated body of volunteers. All of the people who are working with you and belong to the Association. Mrs. Smith and I happen to belong to the Western New York Mental Health Association, and I know that this sort of progress that you people are interested in would never take place, or would be slower, without a lot of dedicated volunteers.

I know that. This country and different parts of this country has made great progress in the last—1953, say—in the last 19 or 20 years. I think the record will show that there was a great deal done in this field, and I think it has made a great deal of progress, mostly through the efforts of dedicated volunteers. There is a long way to go. And I hope that you people will continue, and will call others to help in the effort.

And I think your testimony today is outstanding and very well done, very well presented. Thank you very much.

Mrs. Bregman. Thank you.

We have with us a child psychiatrist in private practice in the District of Columbia, Dr. Eva Townes. She is also the president of our professional advisory board, and she has a very short message that will add to what we have said.

Mr. McMillan. Just a second, please.

Mr. McKinney. Mrs. Bregman, I would just like to apologize for missing some of your testimony. I am on the Board of the Child Guidance Clinic in Bridgeport, Connecticut, and I think I would like to have you come up and visit. In our case, through the United Fund and the City Council, I don't get half as far as you do. Forgetting the human suffering which you are alleviating by setting up this type of program, we also know that this type of program costs government a great deal less.

Mrs. **Bregman**. Sir, we have brought with us a chart which shows the estimated savings and it is so graphic. As you can see over here, if we had the four treatment centers, we would be able to treat to 1600 children per year. It would cost us 4 million dollars a year to operate them. And, if only half of those children are saved from institutionalization, we save 135 million dollars.

Secondly, if we could provide special education for the 1500 children who cannot now receive it, and if one-quarter of those children are prevented from needing institutionalization we save 64 million dollars. If we would be able to help the children in foster homes, at a cost of three-quarters of a million dollars annually, and if we helped one-quarter of those children, so that they would never need institutionalization, it would save 20 million dollars.

So you see, if we helped one-third of the children and if we kept one-third of those 3,600 children from ever needing institutionalization, we save 200 million dollars in what it would cost. But, there is another facet to think of too, because if these children are helped when they are 7, 8, 9 and 10, and then grow up and become productive human beings, we can expect that they will be paying taxes for 40 years—both federal and state taxes.

So, not only are we losing money by not helping them, we are losing a great deal in human potential.

Mr. **McKinney**. You are definitely invited up to Connecticut. I would just like to emphasize the point that this is what you are talking about, really, a better human treatment, but you are also talking about saving money.

For instance, we know that to put a young drug addict in a jail costs as much in the state of Connecticut as it would cost to send three children to Yale University. But to put him into a treatment center program would cost about 2,700 dollars a year. And, I think this is what your message is. That treatment in centers is far, far cheaper for society than the incarceration. Also, I would like to just put into the record to add to your point that we have a new Goodwill in Bridgeport using basically retarded and those with severe mental problems.

As of our first year's accounting of the new one and this includes a residential center, which is a terribly expensive thing to operate, 93.1 per cent of the operational cost of that facility has been returned to the facility in the form of production and services of the people in it. And, I think any time the taxpayer or the private citizen can build a facility and save the money and maybe return even 50 per cent of its operating cost, we're ahead in the game.

Thank you very much.

Mrs. **Bregman**. Thank you.

Mr. **McMillan**. Thank you. We will hear from——

Mrs. **Bregman**. Yes, Mr. Chairman. Dr. Eva Townes, the Chairman of our Professional Advisory Board, an eminent child psychologist.

Dr. **Townes**. Mr. Chairman and Committee Members. Childhood is an opportune time, ordinarily, to interfere with an emotional illness before pathological characteristics become a fixed pattern. It is much easier to mend a young sapling than to alter the distortion of an ancient oak. Children and youth right now, as I see it, are in crisis. The emotional illness of the young is of epidemic proportions. The crisis is highly visual. Witness the drug scene. Reflect on the stoney faces of the runaway children wandering aimlessly on our streets and our highways.

If you could turn the clock back, there was a time when these children were available for help, more available than they are now. Now, for some it is already too late because they have tuned us out. There are other children, though, young children who are in great emotional pain. They have some idea of their needs. I know their needs.

Their family is aware of the fact that their is a need. And I guess this morning, we would like to leave with you some impression of the needs. Inadequate funding is tantalizing to the novice in the field. But to those of us who have been around a little while, it only is a little bit akin to being invited to a banquet receiving a stimulating appetizer and waiting for the main course that is never, never going to come.

Seniority in this field gives you another vision and an opportunity to look at some of the failures, failures that I refuse to take as a personal failure. I share in the failure—in the failure of the system.

Last year as a Consultant at St. Elizabeths, I had the opportunity to see again the child I had seen in 1963 as she got on this treadmill that goes nowhere. I saw her in the Juvenile Court. I had moved into another agency as a Consultant at St. Elizabeths. And, this child appears—8 years older, more ill, more difficult for us to reach. If we can reach her, I am sure it would be a much more expensive proposition than if recommendations that I made and other official agencies made at that time could have been followed through.

Seniority also gives us the liberty to make predictions. And, you can look at a child and know that with the failure of the system, that this child is not going to make it, though you know what is needed. And, it is a bitter sense of fulfillment when you see that indeed the prediction has come into being. If professionals really took a cold look at what it means in leaving the office and going out into the community to work, you realize that you put yourself on the spot as a scapegoat. You get involved in trying to fulfill, to try to motivate, stimulate, treat a human being and to move him on. But because of the inadequacies of budgeting it cannot be done.

And, the mental health professional who is not there becomes a scapegoat, the one that can be looked at and hooted at. But, I still maintain that it is the responsibility of most psychiatrists to try to get out of the office and out into the community. And, I think that this responsibility for mental health care does not stop with professionals. But, it begins to enter here, and it is also part of your responsibility.

Thank you.

Mr. McMILLAN. Thank you very much. Mr. Smith.

Mr. SMITH. Yes, Mr. Chairman. Dr. Townes, I am wondering suppose you have the intensive care residential centers established in this city. And, I think Mrs. Bregman mentioned the possibility of treating some 1600 children a year, 400 at each one, I think a hundred residential and——

Mrs. BREGMAN. Sorry, it was 20 residential and 18—But, that would be a shifting population. That would not be a continuous population. That is an estimate.

Mr. SMITH. Could such facilities be staffed with adequately trained professional people. Is there available that amount of trained people who can adequately staff these centers?

Dr. Townes. I think that there is adequate professional help, adequate paraprofessionals available to staff such a facility if they were available.

Mr. Smith. I ask that question because I used to be a Board Member of a foundation that was doing exactly this same thing, and at that time, and that was some ten or twelve years ago, it was very difficult to find a qualified director and qualified staff people in that one fairly small clinic, and I just wondered whether in the interim in the last ten or twelve years, whether the supply of professionally trained people had increased.

Dr. Townes. I think it has increased, and I think that the utilization—this is a problem; it is a multidiscipline problem, and I think that there are old standards where there was a triumverare and a limited number of people, but I think that things have broadened and there are many people involved, and I think the creation of adequate facilities will stimulate more interest and will bring people into a situation where they would not feel that they had gone in with their hands literally tied.

Thank you very much.

Mr. McMillan. Mr. McKinney?

Mr. McKinney. I just want to underline that point.

What you're saying, Doctor, aren't you, is that a great many people with the proper training just can't stand the total and complete frustration of the incompleteness of their ability to deal with the problems so that people have stayed somewhat purposefully away from the problem iteslf.

Dr. Townes. Absolutely.

Mr. McKinney. Also, I know in our very small facility we have greatly increased the case loads through new methods of dealing with children.

Is this also true?

In other words, that you can train—one trained professional can deal with a great many more children effectively now because of group therapy and things of that type that we basically weren't too attuned to twelve or fifteen years ago?

Dr. Townes. Another factor that we added in the District here, contract services, Dr. Noel has contracted out some services to other groups when there weren't people hired in the government to take care of them, and I do think that there are new approaches and new people involved in trying to create and maintain mental health.

Mr. Fowler. In my five years with the D.C. Mental Health Service, we have never had trouble utilizing or locating proper professional help. I think Washington is blessed in this respect.

Dr. Simmons. Another very important issue with regard to staffing has to do with this is a metropolitan area where we have at least three medical schools and psychiatric institutes for the training of psychologists, and also these centers could be utilized as a living laboratory and these people could come there as part of their training and this would also help to cut back on the amount of money that would have to be allocated for utilization in staffing and hiring people on a permanent basis.

Mr. Smith. We appreciate that comment. I think that that's true.

Mr. Camlin. Mr. Chairman, regarding manpower, speaking out of the context of the National Association for Mental Health, Public

Affairs Committee, thereby knowing something of the manpower availability throughout the country, I would say that the greater D.C. area and the Ann Arbor area are known throughout the country as the more prestigious, more available sources of manpower.

Mr. FOWLER. Mr. Chairman, I know the hour is growing very short. I have two requests to make of you.

We have a list of seventeen organizations that support our position and I would like to have that submitted for the record. I will not read the names of the organizations at this time.

Mr. MCMILLAN. How many of these statements do you think we should have inserted in the hearing in addition?

Mr. FOWLER. Oh, we can give you as many as you need, sir.

We have seventeen organizations, sir.

Mr. MCMILLAN. Well, we will include the complete statements.

(The documents referred to follow:)

LIST OF ORGANIZATIONS AND INDIVIDUALS SUBMITTING SUPPORTING STATEMENTS

Alliance for Psychiatric Progress
Christ Child Institute
Concerned Citizens for Exceptional Children
D.C. Association for Retarded Children
D.C. Council for Exceptional Children
D.C. Citizens for Better Public Education
D.C. Congress of Parents and Teachers
D.C. Psychological Association
Mark Twain School
Medical Society of the District of Columbia
Metropolitan Area Mental Health Advisory Council
National Association of Social Workers, D.C. Chapter
Washington School of Psychiatry
Washington Teachers Union
Washington Urban League

ALLIANCE FOR PSYCHIATRIC PROGRESS,
March 13, 1972.

MRS. ROBERT MARTIN,
Public Affairs Committee, D.C. Mental Health Association, Washington, D.C.

DEAR MRS. MARTIN: The Alliance for Psychiatric Progress wishes to take this opportunity to strongly endorse the development of the Residential Treatment Centers as outlined by the Mental Health Administration.

The paucity of service for emotionally disturbed children and adolescents in the District of Columbia is a problem whose ramification affect every segment of our community. This new venture should be seen as the first step in a massive expansion of services to children and adolescents. The Alliance for Psychiatric Progress, therefore, urges the Congress to lend its support by means of adequate funding and legislation proposals put forth before you today by the D.C. Mental Health Association.

Sincerely,

LEON WHITT, M.D., *President.*

THE CHRIST CHILD INSTITUTE FOR CHILDREN,
Rockville, Md., March 6, 1971.

MRS. LLOYD SYMINTON,
Washington, D.C.

DEAR NANCY: This letter is my reaction to the D.C. Mental Health Association Committee's Statement of Principles on devices for Emotionally Disturbed Children in the District of Columbia. I enthusiastically agree with the statement. There must be a spectrum of mental health services from the simplest and earliest preventive measures at one end to the most elaborate intervention for the most disturbed children at the other end.

As Clinical Director of Christ Child Institute, I have a particular interest in and knowledge about residential facilities, and I would like to emphasize the great unmet need in the District for such help. This type of care is expensive but essential for certain children to become functioning adults. Aside from consideration of human suffering, such facilities much more than pay for themselves economically by turning children who are sure to be burdens on society in jails or state hospitals into assets to their communities. These facilities need to be near the child's home so that parental visiting and psychotherapy for parents is not impaired by the obstacle of distance (such as we experience with District residents). I disagree with the idea of making facilities for only ten children. The children need to be grouped according to age, academic and social abilities. This requires around twenty-five to thirty children aged 5 to 12. Otherwise, you must limit admissions to those children who will fit in with the children you have. Adolescents should be in a separate facility.

The question about the number of beds needed in the District is a most difficult one to estimate. We are talking not about the number of severely disturbed children but the number who can use treatment, for tragically substantial numbers are beyond even ideal treatment. Using some knowledge of the Junior Village population as a rough gauge, I would say it is safe to consider the need running well into three figures, and it could be several hundred.

I hope this will be of a little help toward a very important goal.

Sincerely,

William B. Clotworthy, Jr., M.D.

Concerned Citizens for Exceptional Children
of the District of Columbia,
Washington, D.C., March 8, 1972.

Hon. John L. McMillan,
Chairman, House District Committee,
U.S. Capitol, Washington, D.C.

Dear Sir: We submit the following supportive statement in regard to hearings before your committee on March 14, 1972 with the D.C. Mental Health Association for residential treatment centers for emotionally disturbed children and a special education law for all physically and mentally handicapped children.

Our organization encompasses over 25 agencies serving all of the handicapping conditions, in addition to parents of the physically and mentally handicapped and interested citizens.

TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN

The District of Columbia and its mental health administration under the Department of Human Resources has never substantially addressed itself to the needs of the emotionally disturbed child. This is the child who becomes excluded from school, who is most likely to get in trouble with the law, or winds up at St. Elizabeth's because no community based treatment center is available, often only a temporary need. Residential treatment facilities in each Health Area of the city for about 20 children each, are an absolute necessity in the care of the emotionally disturbed. These centers would provide comprehensive, professionally-directed services which could be coordinated with other existing services like the public schools or a job training situation.

We recommend the possibility of seriously considering a mechanism whereby these publicly funded centers might perhaps be privately serviced in order that needy children do not get lost within the labryinth of the Department of Human Resources.

SPECIAL EDUCATION LAW FOR ALL PHYSICALLY AND MENTALLY HANDICAPPED CHILDREN

Our efforts on behalf of the right of the handicapped to receive a publicly funded education have proven to us that extensive, detailed legislation governing the rights of all physically and mentally handicapped children, is a long overdue necessity in the District of Columbia. Recent exposure of problems at Forest Haven (the District's residential institution for the retarded) and problems concerning exclusion of handicapped children from the public schools, as evidenced by a class action suit now in process against the District Government, all point to an urgent need for a special education law. Many states, over 50%, have enacted detailed laws governing the rights of all mentally and physically handicapped children.

The District's statute reads as follows:

. . . the board of education may issue a certificate excusing a child from attendance if the child is found mentally or physically unable to profit from attendance in school, upon examination ordered by the board. If the examination shows that the child may benefit from specialized instruction adapted to his needs, he shall attend if such instruction is available."

In view of the above statute which gives none of the advantages to the handicapped we feel it is urgent that the duties of both the public school and the Department of Human Resources be made a matter of law in relation to the education and training of the physically and mentally handicapped.

We request the opportunity to discuss this matter further with you at a later date.

Respectfully submitted,

RALPH WITTENBERG, M.D.,
President, Concerned Citizens for Exceptional Children.

D.C. ASSOCIATION FOR RETARDED CHILDREN, INC.,
(formerly HELP FOR RETARDED CHILDREN),
March 7, 1972.

Hon. JOHN L. MCMILLAN,
Chairman, House District Committee,
U.S. Capitol, Washington, D.C.

DEAR SIR: It is our understanding that the D.C. Mental Health Association will be appearing before your Committee on March 14, 1972 in order to present proposals on, a) residential treatment centers for the emotionally disturbed, b) a special education law for physically and mentally handicapped children.

Our organization concurs with the D.C. Mental Health Association in urging the establishment of small (20 children) residential treatment facilities in each Health Area in the District of Columbia. The District has never provided adequate, publicly funded, professionally-directed services for the emotionally disturbed child. These centers would fill a glaring gap and are urgently needed.

We concur also that an urgent need exists in the District of Columbia, for the establishment of a mandatory special education law to insure the right to public education of all physically and mentally handicapped children.

Over 50% of the States have enacted such laws, covering not only education, but placement and screening procedures, and many other important components protecting the handicapped and their rights in our society.

The District of Columbia statutes provide the following:

. . . the board of education may issue a certificate excusing a child from attendance if the child is found mentally or physically unable to profit from attendance in school, upon examination ordered by the board. If the examination shows that the child may benefit from specialized instruction adapted to his needs, he shall attend *if such instruction is available.*" (Emphasis added.)

Our organization is in the process of working on draft legislation for mandatory, comprehensive special education for all physically and mentally handicapped children, including provisions for early screening and diagnosis. We hope for favorable action during this session of Congress.

Respectfully submitted,

ROBERT L. BOSTOCK,
ROSALIE IADAROLA,
Co-Chairmen, Governmental Affairs Committee.

WASHINGTON, D.C., *March 7, 1972.*

Hon. JOHN L. MCMILLAN,
Chairman, House District Committee,
U.S. Capitol, Washington, D.C.

DEAR CHAIRMAN MCMILLAN: As teachers in Special Education we know there is a dire need for a public residential psychiatric treatment program for emotionally disturbed children in the District of Columbia. It should provide comprehensive professionally-directed services for the children in collaboration with their parents or foster parents close to the home.

For continuity and consistency, the program should include residential treatment facilities providing a therapeutic living experience. The lack of such facilities represents a glaring gap in public treatment services needed for emotionally disturbed children at this time.

We concur with the D.C. Mental Health Association in urging the establishment of one such small (20 children) residential treatment facility in each Health Area. These are necessary components of a continuum of comprehensive care (from preventive services to aftercare and rehabilitation) which can be coordinated with the services of other existing agencies.

Very sincerely,

ORELIA W. LEDBETTER,
President, Chapter 49, D.C., Council for Exceptional Children.

DISTRICT OF COLUMBIA CITIZENS
FOR BETTER PUBLIC EDUCATION, INC.
Washington, D.C., March 7, 1972.

MEMORANDUM

To: House District of Columbia Committee.
From: D.C. Citizens for Better Public Education, Inc.
Subject: Legislation Regarding Special Education Programs in the District of Columbia.

D.C. Citizens for Better Public Education strongly supports the enactment of a special education law for the District of Columbia, outlining public concern and responsibility for the education of *all* handicapped children.

Nothing illustrates the need of such a law as clearly as the wording of the present statute which effectively absolves the school system of any responsibility for that portion of the student population in greatest need of educational services.

We urge that the House District of Columbia Committee give first priority to a more meaningful law and the necessary funds to support it.

DISTRICT OF COLUMBIA CONGRESS OF PARENTS AND TEACHERS,
Washington, D.C., March 7, 1972.

Hon. JOHN L. MCMILLAN,
Chairman, House District Committee, U.S. Capitol,
Washington, D.C.

DEAR CONGRESSMAN MCMILLAN: A special education law is needed in the District of Columbia to establish public policy and to protect the right to public education for all physically and mentally handicapped children.

At least 50% of the States already have enacted such laws, many in great detail. In contrast, the District of Columbia statutes provide the following:

". . . the board of education may issue a certificate excusing a child from attendance if the child is found mentally or physically unable to profit from attendance in school, upon examination ordered by the board. If the examination shows that the child may benefit from specialized instruction adapted to his needs, he shall attend *if such instruction is available.*"

This "provision" leaves these especially vulnerable children completely unprotected and at the mercy of administrators who are not mandated to assure that the services are made available. It is essential that these children's rights be made a matter of law.

Also, there is a dire need for a public residential psychiatric treatment program for emotionally distrubed children in the District of Columbia. It should provide comprehensive professionally-directed services for the children in collaboration with their parents or foster parents close to the home.

For continuity and consistency, the program should include residential facilities providing a therapeutic living experience. The lack of such facilities represents a glaring gap in public treatment of services needed for emotionally distrubed children at this time.

The D.C. Congress of Parents and Teachers concurs with the D.C. Mental Health Association in urging the establishment of one small (20 children) residential treatment facility in each Health Area. These are necessary components of a continuum of comprehensive care (from preventive services to aftercare and rehabilitation) which can be coordinated with the services of other existing agencies.

Sincerely,

MRS. PETER ANGELOS,
Chairman, Mental Health Committee, D.C. Congress of Parents and Teachers.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Rockville, Md., March 8, 1972.

JULIETTE M. SIMMONS, M.D.,
District of Columbia Mental Health Association, Inc., Washington, D.C.

DEAR DR. SIMMONS: The D.C. Psychological Association is very pleased to support your efforts for small residential treatment settings for emotionally disturbed children and for a law providing mandatory education and training for physically and mentally handicapped children. Enclosed is a letter I have drafted to Representative McMillan for this purpose.

When I read your letter and the statements you had enclosed to our Board of Directors there was some subsequent discussion regarding the possibility of our own Association taking a more active role in legislative matters of this nature.

Would it be possible for me to meet with you or other members of your Association to explore the possibility of our working more closely on these issues of mutual concern? If you feel such a meeting would be useful please contact me at 443-3527.

Sincerely,

ALLEN RASKIN, Ph.D.,
President, D.C. Psychological Association.

DISTRICT OF COLUMBIA PSYCHOLOGICAL ASSOCIATION,
March 8, 1972.

HON. JOHN L. MCMILLAN,
House District Committee, U.S. Capitol, Washington, D.C.

DEAR SIR: Recognizing the need for a public residential psychiatric treatment program for emotionally disturbed children in the District of Columbia, the District of Columbia Psychological Association concurs with the D.C. Mental Health Association in urging the establishment of small residential treatment facilities in each Health area. The opportunities for comprehensive care and individualized treatment will be immeasurably enhanced in such settings in contrast to the treatment these children would receive in a large institutional setting.

The Board of Directors of our Association also urge support of a special education law for the District of Columbia to protect the right to public education for all physically and mentally handicapped children. Present statutes in the District of Columbia provide for such specialized training on the basis of examination and only "if such instruction is available."

We would be very grateful for your support of these proposals.

Thank you.

Very truly yours,

ALLEN RASKIN, Ph.D.,
President, D.C. Psychological Association.

MARK TWAIN SCHOOL,
Rockville, Md., March 2, 1972.

MRS. BETTY MARTIN,
Mental Health Association of Washington D.C.,
Washington, D.C.

DEAR MRS. MARTIN: Dr. Juliette Simmons suggested that I write to you in regard to a forthcoming meeting of your committee with Congressman McMillan.

It has been recognized for many years by those of us concerned with services to the mentally ill that facilities for those unable to pay or to pay much are terribly inadequate. This inadequacy is compounded when we consider facilities for mentally ill children as highlighted by the report of the Joint Commission on Mentally Ill Children. This deficiency exists to a serious degree in the City of Washington as well, of course, as in other cities. Services provided by such facilities should include provisions for prevention, early detection with intervention, residential services when needed and provision for follow-up. Such services are greatly relevant to our interest in reducing the incidence of delinquency, crime and family breakdown.

I endorse your efforts and wish you success.

Sincerely,

GEORGE P. BROWN, M.D.,
Child Psychiatrist, Mark Twain School (Formerly Supt., Institute for Children, Owings Mills, Maryland).

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA,
Washington, D.C.

There is an urgent need for a comprehensive public psychiatric treatment program for emotionally disturbed children in the District of Columbia. Such a program should provide comprehensive professionally-directed services for the children in collaboration with their parents or foster parents close to the home.

For continuity and consistency, it is of the utmost importance that the program include residential treatment facilities providing a therapeutic living experience. The lack of such facilities represents a glaring gap in public treatment services needed for emotionally disturbed children at this time.

We concur with the D.C. Mental Health Association in urging the establishment of one such small (20 children) residential treatment facility in each Health Area. These are necessary components of a continuum of comprehensive care (from preventive services to aftercare and rehabilitation) which can be coordinated with the services of other existing agencies.

DARRELL C. CRAIN, M.D.
President, Medical Society of D.C.
PAUL CHODOFF, M.D.,
Chairman, Committee on Mental Health, Medical Society of D.C.

METROPOLITAN AREA MENTAL HEALTH ASSOCIATIONS ADVISORY COUNCIL, CONSISTING OF ALEXANDRIA, VA., DISTRICT OF COLUMBIA, MONTGOMERY COUNTY, MD., NORTHERN VIRGINIA AND PRINCE GEORGES COUNTY, MD. MENTAL HEALTH ASSOCIATIONS

STATEMENT SUPPORTING THE NEED FOR A PUBLIC RESIDENTIAL PSYCHIATRIC TREATMENT PROGRAM FOR CHILDREN IN D.C.

(Adopted at Meeting February 23, 1972)

There is a dire need for a public residential psychiatric treatment program for emotionally disturbed children in the District of Columbia. This need is already recognized in the suburbs with such facilities already established in Arlington, or funded and in the active planning stage in Northern Virginia. It should provide comprehensive professionally-directed services for the children in collaboration with their parents or foster parents close to the home.

For continuity and consistency, the program should include residential treatment facilities providing a therapeutic living experience. The lack of such facilities represents a glaring gap in public treatment (service needed for emotionally disturbed children at this time.)

We strongly urge the establishment of one such small (20 children) residential treatment facility in each Health Area. These are necessary components of a continuum of comprehensive care (from preventive services to aftercare and rehabilitation) and would be coordinated with the services of other existing agencies.

NATIONAL ASSOCIATION OF SOCIAL WORKERS,
Washington, D.C., March 8, 1972.

STATEMENT SUPPORTING NEED FOR SPECIAL EDUCATION LAW FOR THE DISTRICT OF COLUMBIA

The Metropolitan Washington Chapter of the National Association of Social Workers is in support of the House District Committee establishing funds to be part of the annual appropriation for the District of Columbia so that it would be mandatory that special education and residential treatment be provided to children in need of treatment and financial assistance.

RICHARD SAVA, ACSW,
Co-Chairman, Mental Health & Psychiatric Services Council.
MRS. GRACE C. MARSHALL,
Co-Chairman, Mental Health & Psychiatric Services Council.

THE WASHINGTON SCHOOL OF PSYCHIATRY,
Washington, D.C., March 7, 1972.

JULIETTE M. SIMMONS, M.D.,
Mental Health Assoc., Inc.
Washington, D.C.

DEAR DR. SIMMONS: The Washington School of Psychiatry is entirely in support of the efforts to provide a public residential psychiatric treatment program for emotionally disturbed children in the District of Columbia. Especially needed is the early establishment of a facility in each health area which would permit comprehensive care for the children and collaboration with those responsible for the home care of the child. Although we are unable to join you in your appearance before the House District Committee, please go with the assurance that you have have our full fupport.

Sincerely yours,

ROBERT G. KVARNES, M.D., *Director.*

THE WASHINGTON TEACHERS' UNION,
Washington, D.C., March 8, 1972.

Mrs. ROBERT MARTIN,
Co-Chairman, Public Policy Committee, D.C. Mental Health Association, Washington, D.C.

DEAR MRS. MARTIN: The Washington Teachers' Union supports the concept that equal educational opportunities should be provided for all of the children of the District of Columbia who wish to attend the public schools. All children including the physically and mentally handicapped should be provided full educational opportunities.

The current statute which permits the Board of Education to exclude children who are found mentally or physically unable to profit from attendance in school is outdated and discriminatory. The rights of children must be protected by law. Therefore, an amendment to the statute is in order.

The Union calls to your attention the fact that if the law is amended, it must be accompanied by the additional funds needed in order to provide the services for the children. If this is not done, then nothing will have been accomplished. To demand new services without providing funds is self-defeating.

It is hoped that favorable action will be taken on both aspects of the problem.

Respectfully,

WILLIAM H. SIMONS, *President.*

WASHINGTON URBAN LEAGUE, INC.,
Washington, D.C., March 3, 1972.

Hon. JOHN L. MCMILLAN,
Chairman, House District Committee,
U.S. Capitol,
Washington, D.C.

DEAR CHAIRMAN MCMILLAN: The Washington Urban League joins with the District of Columbia Mental Health Association in urging the establishment of at least one residential treatment facility in each health area of the District of Columbia.

We see these facilities as necessary components of delivering comprehensive health care to the residents of the District. The need for such public residential psychiatric treatment programs for emotionally disturbed children in the District of Columbia has been documented time and time again. Such a program must provide comprehensive professional services for the children in collaboration with the parents or foster parents and we feel strongly that these facilities should be located within a reasonable proximity to the child's home. Such facilities should provide the therapeudic living experiences which could better enable Health Administration to service this dire public need.

Additionally, a Special Education Law is needed in the District of Columbia to establish public policy and to protect the right to public education for all children. Over half of the states already have enacted such laws, many in great detail. Unfortunately, the District does not recognize the rights of physically and mentally handicapped children to be adequately educated to the full limit of their potential regardless of physical or mental handicaps.

We reiterate for emphasis our concurrence with the District of Columbia Mental Health Association in addressing these two vital areas of concern to the Committee.

Sincerely yours,

MRS. ANNE B. TURPEAU,
Acting Director, Washington Urban League.

DISTRICT OF COLUMBIA MENTAL HEALTH ASSOCIATION BEFORE THE DISTRICT OF COLUMBIA COMMITTEE, UNITED STATES HOUSE OF REPRESENTATIVES

Mr. William E. Fowler, Jr., President, D.C. Mental Health Association, Suite 100, 3000 Connecticut Avenue, N.W., Washington, D.C. 20008.

Juliette M. Simmons, M.D., Mrs. Robert Martin, Co-Chairmen, Public Affairs Committee.

Ad Hoc Committee on Childhood Mental Illness

Mrs. Sandra Bregman
Mrs. Juanita W. Braddock
Mr. Ben Rathbun
Mrs. Yetta W. Galiber
Mrs. Nancy G. Symington
Mr. John L. Gibson
Mrs. Ethel Dalmat
Miss Alice Dodge
Mr. Fred A. Little
Eva R. Towns, M.D.
Mrs. James K. Shiver

Staff

Reverend Milton F. Gay, Executive Director, D.C. Mental Health Association.

Mrs. Barbara Luther, Associate Director for Program, D.C. Mental Health Association.

(The complete statement of Mrs. Bregman, on behalf of the D.C. Mental Health Association, follows:)

NEEDS OF THE MENTALLY ILL CHILD IN THE DISTRICT OF COLUMBIA

The D.C. Mental Health Association would like you, Mr. Chairman, and the members of your Committee, to know how deeply appreciative we are that you have given us this opportunity to talk to you about the plight of the mentally ill child in the District of Columbia.

Although we, as a chapter of the National Association for Mental Health, speak for all the mentally ill, not only children, we feel it is imperative that we give priority to the problems of children and adolescents in the District of Columbia, because that is where the need is the most acute; that is where the hope for change is the greatest.

In 1970 the National Association for Mental Health and its forty-seven Divisions throughout the nation with a membership of hundreds of thousands, focused on "Children in Crisis"—the problems of the mentally ill child in America. Our mental health association, fulfilling its commitment as the voice of the consumer-citizen, as the advocate for those persons who are already seriously ill and those who might be prevented from becoming seriously ill with preventative measures, has pursued the critical needs of children in this city, with few results.

At this point, I want to make it very clear that we do not speak for the Mental Health Administration or for any other part of the District government. Though our members sit on advisory task forces in a consultant capacity to the Mental Health Administration, we are in no way beholden to the city government. We speak only for the citizens of the District; especially for those in need of mental health help.

More specifically we speak for some four thousand members, and a 40-member Board of Directors that represents the entire metropolitan area. Our Board represents all ethnic groups, the socio-economic spectrum, the laymen and the professional. We have businessmen, inner city parents, doctors, social workers, teachers, and lawyers on our Board. We also have a Professional Advisory Board made up of the most outstanding members of the mental health profession in the city.

the Department of Education, took her seat wearily, and said: "I have to see spring come, we have so many suicide attempts in the schools each spring."

When we speak of mentally ill children, there is a vast range of severity in describing their condition and their needs. One thing is certain: when a child begins to develop problems, if that child is not helped then, he will only get worse. The sooner a child in trouble can be diagnosed and helped, the greater the chance that his illness will not become severe.

I would like to tell you about the calls for help we receive in our offices, calls which leave us depressed and frustrated because the appropriate facilities and services simply do not exist in D. C.

- The wife of a United States Congressman, an Urban Service Corps public school volunteer, called asking us to recommend a residential facility for a seriously disturbed 14 year old girl who talks and talks, walks around the streets looking for her mother who deserted her, or shuts herself up in closets. She will not stay in a classroom. She has no money.
- A private psychiatrist tells us she is keeping four disturbed children in her home along with her own children rather than let them go to an inappropriate institution or back to their own homes which have been the primary cause of their illness.
- The Social Worker at the Hospital for Sick Children reports that a 12 year old boy with an I.Q. of 130 was sent to their institution from Junior Village in a catatonic state after 13 previous moves around different foster homes. He was an asthmatic, so the hospital, which is not a psychiatric facility, could take him in. He made a phenomenal adjustment and was placed in another foster home from which he was rejected in two days. When he was returned to the hospital, he threatened suicide. He was finally sent back to Junior Village and kept under lock and key.
- At this same hospital they have a boy who is a cyclical vomiter. He saw his father burn his mother to death.
- We had a school counsellor call asking for help. She had a bright but uncontrollable 6th grade girl who brings a pocket knife to school and threatens the other children. Did we know of any residential facility this girl could be placed in?
- Two of our Board Members witnessed a 13 year old girl screaming and banging the walls of the detention room at Juvenile Court for 45 minutes. At five p.m. when the Judge returned from hearing cases they asked him what was wrong with the girl. He replied that she was "obviously psychotic." They asked him what would happen to her that night. He said she would be returned to the Receiving Home and, if there was anyone there to do so, someone would give her a tranquilizer.

We hear of hundreds of cases like these each year. And there is nothing we can recommend because there is no place for these children in Washington.

At the conclusion of this statement, Mr. Chairman, I would like to introduce to you for an informal conversation, three citizens who will tell you about their frustrations in trying to help emotionally ill children in this city: the mother of a disturbed child, a child psychiatrist in private practice, and the Director of the Information Center for Handicapped Children.

WHAT IS AVAILABLE FOR THESE CHILDREN?

I would now like to turn your attention to the facilities and services the Mental Health Administration and the private sector provide for these 30,000 children.

Our Association conducted a survey in 1970 to determine what was available both in the public and private sector to help these children. A copy is attached. (Appendix C)

There are no public residential treatment centers for seriously ill children. There are less than 60 beds in the entire public sector for children, which includes St. Elizabeths. There are seven private facilities—among the finest in the country—capable of treating three hundred children at a cost of from $11,000 to $26,000 per child, per year. These seven private institutions, in addition to being beyond the means of all but the affluent families, have long waiting lists.

The Mental Health Administration has two day care centers caring for 44 children and two therapeutic nurseries caring for 17 children. Yet we have thousands of small children—under six—who are seriously emotionally disturbed, and require special care.

What does all this add up to—in terms of the vast numbers of children needing help? Not very much at all, as you can see.

In fact, we send 505 children at a cost of $1,300,000 per year on tuition grants to residential treatment centers—some as far away as Texas—because there are not enough appropriate facilities here. There is a waiting list of 398 children for these tuition grants.

It is the opinion of our Association that the highest priority need for children is the creation of a system of four comprehensive care centers, located in the four health areas of the city, A, B, C, & D. Each of these centers would care for 100 patients on a daily basis, with residential facilities for twenty out of the 100 children.

"Residential treatment" is essentially a therapeutic milieu designed to provide corrective life experiences to counteract the damaging and painful experiences which led to the child's emotional disturbance. Residential treatment provides a variety of programs that include various forms of therapy (individual and group), education, nursing care, and the other kinds of adult supervision required for 24-hour living. The basic elements in treatment are "people, things and cultural patterns" within a consistent, planned and controlled environment. This requires a staff of skilled personnel, trained and experienced in working with children, and able to collaborate in a complex and highly varied program. Such a program also requires close collaboration with people in the child's natural environment, such as parents, other family members and teachers. It should often include supportive therapy with the family. It also requires out-patient facilities for use as the child moves toward community living.

These residential facilities are necessary for youngsters with severe emotional disorders and mental illness. The severity of their disorders presents extremely complex problems: those of deep emotional hunger, extreme over-activity, withdrawal from the outer world, extremely high levels of aggression, violent uncontrolled behavior, bizarre and incomprehensible reaction patterns. A wide range of services are essential for the full care of such children. These children need more than individual treatment; they need an all-embracing care which is therapeutic in nature and which includes attention to their total development. For instance, they need individualized, highly skilled attention to their educational and recreational needs; and their daily routine needs to be handled with psychological skill.

Obviously, such treatment is expensive. In our local private institutions the cost ranges from $11,000 to $26,000 per child; in the state of Massachusetts where by law all children have been deinstitutionalized (those in correctional facilities, institutions for mentally retarded, etc.) and placed in small residential treatment facilities, the cost per child is estimated at $7,000 per year. The cost of providing residential treatment services at the Espiscopal Church for Children in York, South Carolina is $9,115.50 per child, per year. The Executive Director of the Espiscopal Church Home for Children in York, South Carolina is $9,115.50 per child, per year. The Executive Director of the Episcopal Church Home for Children, Mr. H. S. Howie, Jr., has stated that "without residential treatment services these children would have to spend their adult lives in state institutions." South Carolina's state Senator Waddell has estimated the cost of keeping a child in a state institute for his life expectancy at $1 million dollars for six children. To the cost of keeping a child institutionalized, we must add the other side of the picture . . . the 40 year work expectancy as a productive human being, the loss in state and federal income tax dollars

But even more important than all of this . . . how can we measure the cost of the salvaging of a human personality?

Publications from the National Institute of Mental Health state that the average cost, nationwide in 1969 for residential treatment was $9,855 per child.

The D.C. Mental Health Association urgently requests that this Committee act favorably on legislation creating a system of "comprehensive care residential treatment centers." These centers, one for each geographic area of the city, should be kept small and as homelike as possible.

The Congress has already provided funds for constructing two such centers and $600,000 for operating costs, insufficient to run even one of them based on the program budget and staffing plan designed by Dr. Essex Noel, Director of the Mental Health Administration. (Appendix C)

What we are requesting you to do today is to authorize the creation and operation of four centers or two more than are currently contemplated The additional capital cost we estimate at 1.5 million dollars, the yearly operating cost would be approximately 4 million.

These figures are high, the benefits incredibly higher We would all agree that it is impossible to place a price tag on the saving of a human life. But we also are aware that Congress understandably wants to know what they are buying with every public dollar. Accordingly, if we assume—and this is conservative—that these centers will treat 400 children each every year and that perhaps half of them will, because of the treatment, not have to undergo institutionalization, then, instruction for the mentally disturbed child shall be furnished "if such instruction is available." There are no provisions for identification and placement of the child, financing or enforcement.

There is ample precedent for comprehensive legislation. The statutes of all of the states provide for special education of the disturbed child. They vary dramatically in scope and approach—thus approximately one-half of the states require mandatory special education while the other half adopt a voluntary approach. At their best, the state statutes represent an enforceable commitment to the emotionally disturbed child; at their worst, as in the District of Columbia, they are so vague as to be illusory.

We recognize that laws, of themselves, do not effect an instant cure. Thus 30 states during the 1968–1969 school year were serving less than 11% of their emotionally disturbed children. However, legislation evidences a written public policy to recognize, confront and deal with a social ill. Therefore, we support, and hope that your Committee will support when presented to it, legislation for the District of Columbia which

—Requires mandatory education for the exceptional child.
—Establishes procedures for identification and placement of the child, and ensures due process for the child and family.
—Designates the agency responsible for supervising the program and identifies the program facilities.
—Establishes standards for teacher qualification and administrative staff.
—Sets forth specific requirements for matters such as continuing evaluation, transportation of children, teacher-child ratios.
—Provides for funding and enforcement mechanisms, to guarantee that these funds may only be used for special education and not merged into or diverted to other needs.

I would like to point out, Mr. Chairman, that your own state of South Carolina has enacted legislation creating residential treatment facilities for children; your state also has a statute calling for special education for handicapped children.

Again our cost analysis more than justifies our request. For $3.5 million we can handle an additional 1,500 children. If even 25% of them would otherwise be forced out of the school system into institutions, we will save $64 million over their lifetime, a return of close to 20 to 1.

CHILDREN IN FOSTER HOMES

The third and last recommendation we wish to make today concerns small children placed in foster homes in Washington. There are all kinds of reasons why children must be placed in foster homes, and all the reasons are unhappy. Perhaps their parents are separated, mentally ill, in jail, or have recently died. Sometimes simple poverty is the reason why children must be removed temporarily from their natural parents. There are over 500 children between birth and five years of age currently living in foster homes in the Washington area. Some of these homes are gloomy and dreary.

Even while the search for better foster homes and more skilled and compassionate foster parents goes on, it is imperative that the D.C. government take measures supportive of foster parenthood, and these very high risk children. I say "High-risk" advisedly. A very large percentage of children who have lived in foster homes during the early years of their lives become mentally ill. It is incumbent on us to take preventive measures to protect these children.

The D.C. Mental Health Association embarked on a project five years ago to establish a model of a therapeutic nursery school for children in foster homes. After much careful planning by our most skilled professionals, we opened the "Child Learning Center" at Catholic University of America, in September, 1971. This pilot project, unique in the United States, was funded entirely by money we raised with our annual Bal du Futur.

The Center includes substantive learning of the Head Start type. But more importantly, it's purpose is preventive and therapeutic. The foster mothers assist the teachers, just as mothers in the neighborhood nursery schools do. But here the purpose is for the foster mother to learn specific child rearing rechniques. Also, if problems develop, the teachers and social workers are trained to recognize them immediately and intercede to help the child. Weekly parents meetings are held so parents can explore their problems and discuss ways in which they might be more helpful to their children. This nursery school situation works to build the child's self esteem, strengthen the foster mother's understanding of what is going on inside the child, and give her an outlet for problems with her child.

We have built into this Child Learning Center some minimal evaluation techniques, and we hope to assess how this approach has benefited each child this coming June. Our research results will be general and individual.

It is our firm belief that an early childhood education system, perhaps based on the model we have developed, must be designed to meet the needs of children in foster homes, and be made available as soon as possible to these five hundred children in D.C.

Placing these children in foster homes, rather than a large institution, is both healthier for the children and less expensive to the city. We believe that the money saved by placing them in foster homes should be used to provide supportive services to these high-risk children; we believe this early childhood education system is a must for these children.

At Catholic University we are spending $2,000 per child per year. We believe it could be done less expensively by including more children in each nursery school. (We have only ten children in our Center because the physical facility is very small.) We would estimate that this type of model could be duplicated by the city at a cost of approximately $1,500 to $1,800 per child per year.

Our third request, Mr. Chairman, is that your committee act favorably on legislation creating an early childhood education system specifically geared to the needs of children in foster homes.

We are modestly seeking coverage of only 500 children at the outset, Mr. Chairman. Were one-fourth of them to have to go to St. Elizabeth's or jail, society would have to spend $20 million on them, not three-quarters of a million.

SUMMARY

In summary then, the three requests we make of this Committee today are that it act favorably upon legislation affecting these 30,000 or more children.

We ask you to authorize

I. The creation of a system of four "comprehensive care residential centers" for children and adolescents, to be placed in the four health sections of the city.
II. Enact a mandatory special education law.
III. Create a system of early childhood education facilities, including children in foster homes.

If we go home today, having failed to move this committee to action, then we or some other citizen group will come back in a year or two to repeat this request. Meanwhile, the cost of providing services for those needing special attention will easily be twice the substantiated figures or guesstimates we have unfolded to you today.

The cost to society will be horrendous: wasted lives, wasted human potential. There will be more children on drugs, committing crimes, dropping out of school. Continued neglect of these children can only mean continuation of crime, violence, disrupted classrooms, and innumerable unfulfilled and unproductive lives.

We think alternatives are clear: residential treatment services and special education classes and early childhood intervention programs or more drop-outs, more robberies, more assaults, more Lortons, more St. E's, more wasted lives.

I know this kind of testimony is depressing, but so is reading our daily newspapers. We are past the urgent stage. We must provide treatment for these children who are, by anyone's definition, mentally ill. If we are ever to make a dent in the adult mentally ill population, we must begin by treating the problems of our children. We cannot continue to allow children to be sent to correctional institutions, when what they really need is psychiatric treatment.

I know that you recognize that the children of today represent our nation's future, our most precious national resource. In Washington, this morning, many children are out of school because they are emotionally ill and yet they go untreated. Hundreds more are finding their way to detention facilities at Laurel, or to Juvenile Court—something which could have been prevented if services had been readily available a few years ago.

The need is obvious. Our child-care professionals know how to help these troubled children; we know how to rehabilitate them. What we need from this committee is the commitment to fill the glaring gaps in service which spell disaster for so many of our children.

COST ANALYSIS

Our request	Additional cost annually	Number of children served	Projected savings over institutionalization
I. Four residential treatment centers	$4,000,000	1,600	$135,000,000
II. Special education	3,500,000	1,500	64,000,000
III. Early childhood intervention	750,000	500	20,000,000
Total costs	8,250,000	3,600	219,000,000

INDEX TO APPENDICES

Appendix A: Three definitions of an emotionally disturbed child.
Appendix B: Review of D.C. Facilities for Disturbed Children by the D.C. Mental Health Association.
Appendix C: Budget and Staffing Plan for a Comprehensive-Care Residential Treatment Center.
Appendix D: "Needs Of Exceptional Children In The District of Columbia" Prepared by staff of the Department of Special Education.

APPENDIX A

The Joint Commission on the Mental Health of Children has made the following definition of emotionally disturbed children: "An emotionally disturbed child is one whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment: 1) for reasonably accurate perception of the world around him; 2) for impulse control; 3) for satisfying and satisfactory relations with others; 4) for learning; or 5) any combination of these.

DEFINITIONS

Two descriptions of emotional disturbance are presented to indicate the range of considerations needed in selecting children for residential programs. The first is excerpted from a report "The Needs of Exceptional Children in the District of Columbia" prepared by the Department of Special Education. *Seriously Emotionally Disturbed* individuals exhibit one or more of the following characteristics over a long period of time and to a marked degree.

(1) Inability to learn that cannot be explained by intellectual, sensory or health factors.

(2) Inability to build or maintain satisfactory interpersonal relationships.

(3) Inappropriate behaviour or feelings.

(4) General pervasive mood of unhappiness or depression.

(5) Tendency to develop physical symptoms, pains or fears associated with personal or school problems.

The second description is taken from a booklet "From Chaos to Order," compiled by the American Association for Children's Residential Centers.", in an article on The Therapeutic Milieu. pp. 37–45

"Those disturbed children for whom residential treatment is the choice are among the very sickest, and therefore in dire need of the most intensive and pervasive treatment measures available. (These children) are often psychologically primitive, defective of ego, wanting in realistic self-assessment, impaired in ability to establish meaningful contacts with others, deficient in judgment, backward in the capacity to learn, and woefully innocent of the subtleties of symbolic communication."

APPENDIX B

REVIEW OF D.C. FACILITIES FOR DISTURBED CHILDREN

(by The Sub-Committee on Mentally Ill Children, Children and Adolescents Committee, D.C. Mental Health Association)

CONTENTS

I. Goals and Method
II. Statistical Findings and Comparisons 1965–1971
III. Summary and Comments on Statistics

IV. Areas of Special Concern Expressed by Agencies Working with Disturbed Children
V. Recommendations
VI. Extent of the Problem
VII. List of Agencies Canvassed

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462–1122

May 3, 1971

I. GOALS AND METHOD

The original charge to the sub-committee was to develop proposals for an "ideal" plan for services to mentally ill children in D.C. After reviewing several published programs, and talking with Dr. Michael Fishman, Consultant in Child Psychiatry at N.I.M.H., we found that many plans have already been developed which could be adapted in any community. To name a few:

1. The 1970 Report of the Joint Commission on Mental Health of Children.
2. The National N.A.M.H. Statement "Action Programs in Childhood Mental Health." (1964)
3. The 1966 Survey of the American Association of Psychiatric Clinics for Children.
4. "Mental Health Services for Children" (N.I.M.H. 1968 Report)

All of these list the following services as essential to any program:

1. Out-patient treatment facilities
2. Day centers
3. Twenty-four hour care (hospital and/or residential.)
4. Emergency Services
5. Therapeutic nurseries
6. Consultation and education in principles of mental health, and in family life and planning. Emphasis is on prevention, through a wide range of programs in schools, clinics, homes, parents and children, and personnel working with them.

Because of the availability of these reports, the committee changed its goals to the following:

1. Review of D.C. Health Department's Report on Comprehensive Mental Health Services, 1965.
2. Obtaining up-to-date data regarding services available March-April, 1971.
3. Development of some proposals for priorities which, if not "ideal", might be feasible for the District at this time.

Data was obtained from committee members, and from telephone calls by the chairman to 40 agencies, hospitals and schools serving emotionally disturbed children in this area. (list attached) The two large agencies not covered were the Children's Center at Laurel and the D.C. Public School system, due to complexity of obtaining data, and the availability of figures elsewhere.

II. STATISTICAL FINDINGS AND COMPARISONS, 1965–1971

Due to wide divergences in reporting systems and in the absence of city-wide statistics, we found it impossible to obtain figures which accurately reflect the number of children receiving service. Therefore the figures given on the following tables must be viewed as approximations. They are based on telephone reports of current case-loads and the February 1971 Patient Movement Summary for D.C. Psychiatric Facilities which covers the public and a few private agencies.

TABLE A.—LOCAL FACILITIES AND SERVICES FOR CHILDREN PREEXISTING 1965

	Outpatient	Hospitals	Residential treatment	Day care	Therapeutic nurseries	Special foster homes
Public:						
Facilities	3	3	0	0	0	0
Number under care, 1964	564	(1)	0	0	0	0
Private:						
Facilities	10	2	6	0	0	5
Number under care, 1964	469	(1)	(1)	0	0	[2] 9

[1] Figures not available.
[2] Of these, 7 by contract with welfare departments.

TABLE B.—LOCAL FACILITIES AND SERVICES FOR CHILDREN, MARCH 1971

	Outpatient	Hospitals	Residential treatment [1]	Day care	Therapeutic nurseries	Special foster homes
Public:						
Facilities	4	3	0	2	2	0
Number under care	[2] 1,000	[3] 80	0	44	17	0
Private:						
Facilities	10	2	6	4	3	22
Number under care	[4] 637	75	(5)	[6] 82	39	[7] 32

[1] The Board of Education, Department of Sepcial Education, reports Apr. 1, 1971, a total of 521 children placed throughout the country on tuition grants in residential treatment centers and special schools. Of these, 79 are emotionally disturbed and 30 have neurological disorders. There is a waiting list for tuition grants of 398 children, of which 87 are emotionally disturbed.
[2] Approximately. Reports from 3 centers .No figures from area D.
[3] Approximately.
[4] Figures from 8 only.
[5] 260 beds (40 District of Columbia tuition grants).
[6] 40 District of Columbia tuition grants.
[7] Of these, 26 by contract with SSA.

TABLE C

Private:	
Special schools (day and residential, local only) [1]	8
Enrollment figures from 7 schools	330
Public (Facilities for children of military personnel):	
Residential or inpatient hospital	0
Outpatient	(2)

[1] The Board of Education, Department of Special Education, reports Apr. 1, 1971, a total of 521 children placed throughout the country on tuition grants in residential treatment centers and special schools. Of these, 79 are emotionally disturbed and 30 have neurological disorders. There is a waiting list for tuition grants of 398 children, of which 87 are emotionally disturbed.
[2] Possible 250 (figure incomplete). (Payment for residential care in private facilities is made through CHAMPUS.)

Other special facilities:

1. Howard University conducts a Child Development Center for children with learning difficulties. The Center claims that there are approximately 300 children and adolescents over age 5 under care at this time.
2. Georgetown University Hospital has just opened a University-affiliated Developmental Center for children with developmental handicaps. Figures not obtained.

III. SUMMARY AND COMMENTS ON STATISTICS

The total number of children and adolescents receiving care in all facilities listed here is approximately 2,300. (This excludes the military facilities, and the two facilities for children with learning and developmental difficulties, at Howard University and Georgetown University.

A. *Out-patient care.*—There has been a marked increase in out-patient care since 1965, largely due to the opening of the D.C. Mental Health Centers. The 10 private facilities are not the same as those which existed in 1965, since 5 were closed and 5 new ones opened.

B. *Therapeutic Day Nursery* facilities have increased from none in 1964 to 5 in 1971 (two public), with combined case load of about 56.

C. *Residential Treatment Facilities.*—The figures on residential care are difficult to interpret. For purposes of this report, we listed only those facilities which offer therapeutic care apart from wards for hospitalized adult patients. *There are no public residential treatment facilities for children.* The private ones, with capacity for 260 children, are for the most part outside the District, are very expensive, and have currently only about 40 DC children on DC tuition grants (Total no. of other DC children was not obtained. Most are from this area.) The Psychiatric Institute has just opened 52 beds, and is negotiating with the District for tuition grants. There are no small local residential treatment facilities or group homes (public.)

D. *Special Foster Homes.*—The 22 foster homes for disturbed children, with 32 children, are all under private auspices, with the District contracting.

E. *Private Schools.*—The special private schools for children with learning, developmental or physical handicaps, seem to be the facilities most used by the District school system for tuition grants. There are currently 109 grants in 8 schools with enrollment of 330 children. It appears that these schools rely heavily on the District for financial support, but some of them report that the maximum grant allowed by the District ($3,000 per child) does not cover costs.

IV. AREAS OF SPECIAL CONCERN EXPRESSED BY AGENCIES

Although the Committee was not evaluating quality of services, we felt we should report some of the concerns voiced by the reporting agencies.

A. The major concern seems to be lack of sufficient residential treatment facilities. Particular emphasis was placed on the need for adequate hospital care for the severely disturbed children, and need for residential care for children who do not need to be in hospitals, but lack adequate home care and cannot adjust in school. Such children might make it in the community with supervision and treatment in small residential facilities. As one worker put it "Many of these kids just need plain good parenting." The need seems to be particularly felt by hospital workers who cannot find after care arrangements for their children.

B. Considerable confusion was expressed by some workers about procedures for placement or commitment of children. There appears to be some breakdown between administration and those carrying out the job.

C. Apparently there are professional and administrative differences of opinion about the relative advisability of institutional vs. community living for certain children. Some of this appears to be due to disagreements about diagnosis. Some seems to stem from basic differences in philosophy about where emphasis should be put. This results in inconsistent planning, especially for severely disturbed children whose behavior creates crises, and who are moved all too frequently between family, hospital, foster home and community, with damage to the children and frustration to all those involved.

D. Comments regarding out-patient facilities were generally favorable, except for concern about waiting lists. One person spoke of frequent changes of therapist due to staff turnover, as a major problem. Another raised questions about the extensive use of *para-professionals* in outpatient clinics who are doing treatment of children with questionable adequacy of supervision.

E. The problems of children with learning difficulties can be only touched on here. Comments from workers in some of the special institutions for children indicated that some of the children indentified as retarded by the public schools and sent to these institutions are potentially normal. They improve rapidly in their ability to learn when placed in these special environments. Some are able eventually to return to the public schools.

The Howard University program, which works closely with the schools, is trying, with limited staff, to cope with all kinds of adjustment and learning problems for some 300 children, most of whom have emotional difficulties. This all seems like only the tip of the iceberg of the enormous problems of children in the public schools. One child welfare worker commented that her foster mothers have far fewer problems during the summer months when the children are relieved of the pressures put upon them by the school system!

V. RECOMMENDATIONS OF COMMITTEE

I. There is a great need for a unified system of reporting among both public and private agencies, so that at least on the quantitative side easy and fast identification will be possible (a) of children who need special services and (b) of the services being provided. Chairman found one discrepancy of over 500 children between figures provided by a private facility over the phone, and figures provided by the same facility to the Mental Health Services statistical reporting service (the agency knew of this discrepancy and was in process of evening it up.)

II. From a qualitative viewpoint, there are special reviews made of services and programs throughout the Mental Health Services. These are handled partly by sophisticated statistical analyses.

We would recommend that further qualitative concern is greatly needed. This may be partially under way through increased professional staffing, as well as a better use of para-professionals. Professionals are especially needed to adequately train para-professionals for their heavy responsibilities. Special training programs and adequate supervision for this group is urgently needed, in both the public and private sectors.

III. However, the most urgent priority is residential treatment facilities of all types for children in our community. These should include: (1) more hospital beds for severely disturbed children, separated from adult wards, and providing security and long-term care if needed; (2) additional foster homes for emotionally disturbed children; (3) small group homes for short- or long-term care in the community. These would hopefully be near the child's natural roots. They should provide special milieu therapy, schooling (in community schools where feasible), individual and/or group therapy. Close work with families, schools and community agencies is essential.

The committee sees no value in constructing additional large institutions. What we need in this community is a flexible but *unified* plan for residential care of all sorts, with emphasis on supportive services which will maintain children in their own homes wherever possible, or, that failing, will provide them with substitutes as close as possible to family living.

There are too many children in D.C. today whose problems result from homes which cannot provide for their basic emotional (and often physical) needs. This, in large measure, is due to the fact that the needs their parents had, likewise, had never been met. Having received little, they had little to give. The children who today are caught in this web must be salvaged, so as to preclude, as much as possible, the continuity of this shame and pain!

We must face these facts, here and now. We must plan in an orderly and unified manner, profit from out past mistakes, and put an end to the makeshift, spotty, crisis-oriented, in-and-out care which we *know* only leads to further disintegration of the child's ability to grow into an emotionally healthy adult. This means an all-out effort on the part of the entire community; the schools, hospitals, communication media, Department of Human Resources, private agencies, and above all, our concerned citizens!

ADDENDUM

VI. EXTENT OF THE PROBLEM

By applying to the District of Columbia national percentages from the Joint Commission Report on Children's Mental Health (Fall, 1969), we estimate:

D.C. Children probably psychotic	1, 770
D.C. Children severely disturbed	5,900 to 8,850
D.C. Children needing help with some emotional problem	23,600 to 29,500

Of these nearly 30,000 children, the foregoing report reveals that only about 2,300 were under treatment in public and private facilities as of April, 1971.

VIII LIST OF AGENCIES CANVASSED

OUT-PATIENT CLINICS

D.C. Mental Health Services Area A,B,C,D.
Groome Child Guidance Glinic
Georgetown University Hospital (Child Psychiatry Clinic)
Group Health
Hillcrest Children's Center
Jewish Social Service Agency
Pastoral Counselling
D. C. Institute for Mental Hygiene
Potomac Foundation
Psychiatric Institute

HOSPITALS

Area D In-patient Service
D. C. General Hospital, Area B and Area C (wards)
St. Elizabeth's Hospital
Hospital for Sick Children
Washington Hospital Center
Freedmans Hospital
George Washington University Hospital

RESIDENTIAL TREATMENT CENTERS

Christ Child Institute
Edgemeade
Episcopal Center for Children
Hillcrest Center for Children
Linwood School
Psychiatric Institute
Treatment Center for Autistic Children

SPECIAL SCHOOLS

Agnes Bruce Greig
Christ Church Center
Leary Day School
Occupational Training Center
Pilot School for the Blind
School for Contemporary Education
St. Gertrude's School
St. John's Development Center

THERAPEUTIC DAY NURSERIES

Catholic University Child Center
D.C. Mental Health Areas B and C

DAY CARE

D.C. Mental Health Areas C and D
Christ Child Institute
Episcopal Center for Children
Hillcrest Childrens Center
Psychiatric Institute
Linwood

OTHER AGENCIES (NON-TREATMENT)

Child Welfare Services, Dept. of Human Resources
D.C. Receiving Home
Suicide Prevention Services and Mental Health Consultation, D.C. Mental Health Services Administration

SPECIAL FOSTER HOMES

Family and Child Services
Jewish Social Service Agency

MILITARY ESTABLISHMENT FACILITIES

Walter Reed Army Hospital—Out Patient Psychiatry
U.S. Naval Hospital Psychiatric Service
U.S. Air Force (CHAP)

OTHER SPECIAL PROGRAMS

Howard University Child Development Center
University Affiliated Program—Georgetown Hospital (Children with Multiple Handicaps)

APPENDIX C

BUDGET AND STAFFING FOR YOUTH CENTER (RESIDENTIAL-DAY CARE)

Positions	Number		
GS-15 Director	1		$25,583
GS-13 Assistant director	1		18,737
GS-15 Psychiatrists	2	$26,436	52,872
GS-12 Social worker (Supervisor)	1		15,866
GS-11 Social worker	7	13,309	93,163
GS-9 Teachers	8	11,046	88,378
GS-13 Psychologists	1		18,737
GS-12 Psychologists	2	15,866	31,732
GS-13 Special Education Therapist	1		18,737
GS-11 Nurse (Supervisor)	1		13,309
GS-9 Nurses	5	11,046	55,230
GS-6 Counselors	20	8,153	163,060
GS-6 Secretary	1		8,153
GS-5 Clerk typists	5	7,319	36,595
GS-10 Manual arts therapist	1		12,556
GS-8 Receptionist therapist	3	10,013	30,039
GS-10 Occupational therapist	1		12,556
Bus drivers WG 7/2 3.80 per hour	2		15,808
Housekeepers WG 3	3	6,260	18,780
Food servers WG 3	3	6,260	18,780
Supervisor food server WS 1	1		7,280
Subtotal	70		755,941
		[1]	62,742
		Total	818,683

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[1] 8.3 percent.

Other Costs for Youth Center

	Year
Food (Approx. 1-50 for 3 meals)	$22,000
Medication	15,000
Supplies	25,000
Equipment:	
One year—Excluding beds, kitchen etc.)	30,000
1—small bus	6,000
1-Carry All	4,000
Unforeseen	48,000
Sub-Total	150,000
Personnel	818,683
Grand total	968,683

APPENDIX D

NEEDS OF EXCEPTIONAL CHILDREN IN THE DISTRICT OF COLUMBIA

[Report to the Superintendent, October 15, 1971; October 19, 1971]

(Prepared by staff of the Department of Special Education: Dr. John L. Johnson; Dr. Doris Woodson; Mrs. Dorothy Hobbs; Dr. Enid Wolf)

REPORT TO THE PRESIDENT, WHITE HOUSE CONFERENCE ON CHILDREN 1970, WASHINGTON, D.C.

(Excerpts from Forum 12: "Children Who Are Handicapped." (pp. 195–206).)

—"The child who is affected by handicapping conditions, whether they be physical, intellectual, emotional, cultural, or environmental must be given the opportunity to achieve his maximum potential, no matter how meager or great that might be." (p. 197)

—"Because any child unable to develop his full potential can be characterized as handicapped, we propose that handicapped children be considered just as children rather than as handicapped. Clearly then, to meet the needs of the handicapped, we must also attack the problems confronting the total child care system." (p. 197)

—"Congress has recognized the need for these programs but has not appropriated the funds authorized. We recommend the immediate and full appropriation of these funds, especially for those programs which focus on manpower training and the provision of services for the handicapped." (p. 201)

I. Special Education: General Concern and Definition

Special education is that part of education which devotes its attention to students who after a professional evaluation and/or appraisal are considered to exhibit one or a combination of the following:

impairment: defective bodily structure (senses, systems, organs, members, etc.)

disability: a limitation of activity when compared with other individuals of similar age, sex, and culture.

handicap: a reduction of personal or social efficiency and the stigma therefrom.

These pupils (children and youth) are generally known as "exceptional" in terms of the usual manner of classifying human problems. *A Department of Special Education exists for the purpose of educating those children who are exceptional physically, mentally, or emotionally to the extent that they require special educational services in order to develop to their maximum capacity.*

Special education, in practice, concerns itself with:

a. An altered instructional environment which will attend itself to the educationally significant attributes of the students condition.

b. Specialized materials and methods of instruction.

c. Provision for the interweaving of non-educational therapeutic procedures into an educational process.

d. Teachers with specialized training in education of exceptional children and the temperament to carry out their unique role.

Special educational methods and techniques provide for instruction of children in subject and content but with cognition, perception, language, emotions, and social forces as constant criterion variables which each teacher must know, moniter, and teach to, in a personalized form of instruction.

II. Types of Children to Be Served

A. *Educable Mentally Retarded.*—Mentally retarded individuals who are educable in the academic, social, and occupational areas, even though moderate supervision may be necessary.

B. *Trainable Mentally Retarded.*—Mentally retarded individuals from whom little or no self-support is anticipated, although some improvement in performance is possible, expecially in self-care, social and emotional adjustment, and economic usefulness in the home or a sheltered environment. These individuals probably will require a sheltered environment and major supervision throughout their lives.

C. *Seriously Emotionally Disturbed.*—Serious emotionally disturbed individuals exhibit one or more of the following characteristics over a long period of time and to a *marked degree:*

(1) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(3) Inappropriate types of behavior or feelings under normal circumstances.

(4) General pervasive mood of unhappiness or depression.

(5) A tendency to develop physical symptoms, pains, or fears associated with personal or school problems.

D. *Specific Learning Disabilities.*—Individuals who exhibt a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learining problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, emotional disturbances or to environmental disadvantage.

E. *Crippled and Other Health Impaired.*—Individuals who require an altered learning environment because of:

(1) Muscular or neuromuscular handicaps which significantly limit ability to get about, sit in the classroom or manipulate the materials required for learning;

(2) Skeletal deformities which also affect ambulation, posture and hand use in school work; and

(3) Health ailments which result in reduced efficiency in school work because of temporary or chronic lack of strength, vitality or altertness.

F. *Hearing Impaired.*—Individuals who are diagnosed in terms of:

Deafness—The sense of hearing, either with or without a hearing aid, is insufficient for interpreting speech.

Postlanguage Deafness—Deafness occurred after good language and speech had been acquired.

Prelanguage Deafness—Deafness occurred before a firm establishment of language and speech.

Hard of Hearing—Refers to a loss of hearing which is educationally significant, but residual hearing is sufficient for interpreting speech with—if not without—a hearing aid.

G. *Visually impaired.*—Blindness—20/200 or less in the better eye with the best possible correction or a restriction in field of vision to an angle subtending an arc of 20 degrees or less. Blind children include those who have so little remaining useful vision that they must use Braille as their reading median.

Partial Sight—Remaining visual acuity between 20/200 and 20/70 in the better eye with the best possible correction. Partially seeing children are those who retain a relatively low degree of vision and can read only enlarged print or those who have remaining vision making it possible for them to read limited amounts of regular print under very special conditions. The partially seeing child is one who retains limited but useful vision for acquiring an education but whose visual impairment after needed treatment or correction or both reduced school progress to such an extent that special educational provisions are necessary.

III. Organizazion of Services

The Department of Special Education has organized its services into functional areas of educational programming. Figure 1, The Cascade System, shows what types of services will be available during the coming school year. The tapered design indicates the considerable difference in the numbers involved at the different levels and calls attention to the fact that the system serves as a diagnostic filter. The most specialized facilities are likely to be needed by the fewest children on a long-term basis. This organizational model can be applied to development of special education services for all types of disability.

All existing programs have been re-cast to provide for specific accountability in terms of the delivery of services to pupils and to schools. Each level of service is described in Figure 2. Description of Educational Programs.

DENO, Evelyn – "SPECIAL EDUCATION AS DEVELOPMENTAL CAPITAL"
Exceptional Children, Vol. 37, Nr. 3, pp. 229–237...1970

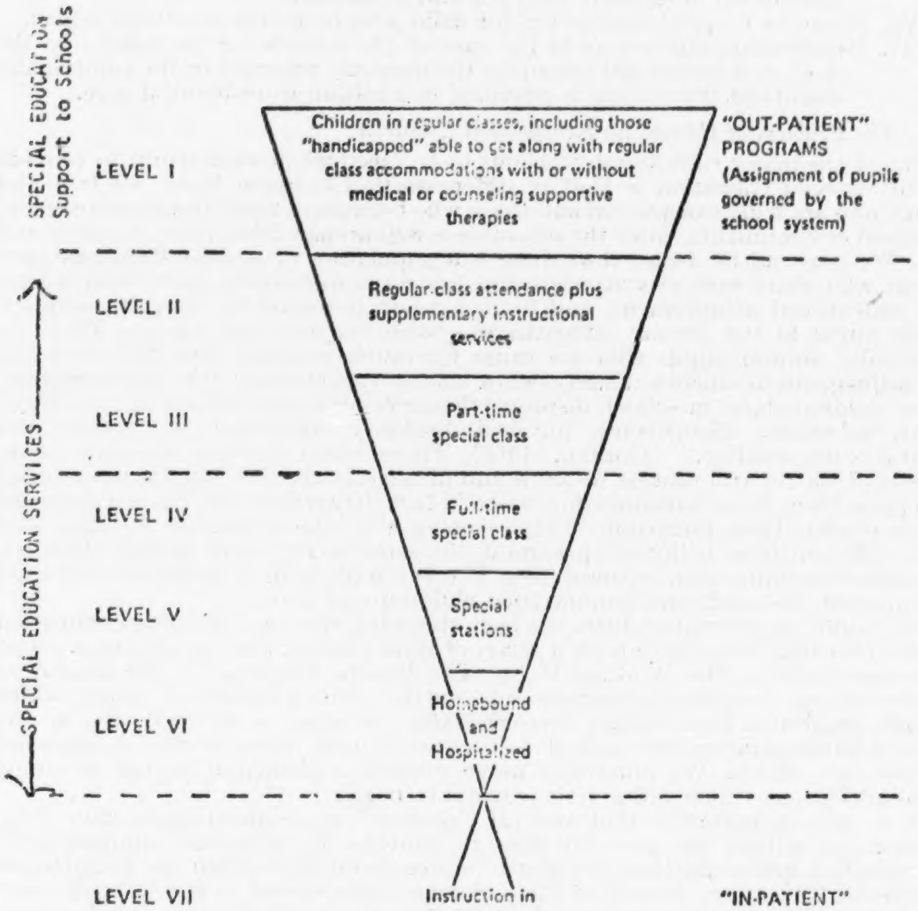
SPECIAL EDUCATION Support to Schools
SPECIAL EDUCATION SERVICES
LEVEL I
Children in regular classes, including those "handicapped" able to get along with regular class accommodations with or without medical or counseling supportive therapies
"OUT-PATIENT" PROGRAMS (Assignment of pupils governed by the school system)
LEVEL II
Regular-class attendance plus supplementary instructional services
LEVEL III
Part-time special class
LEVEL IV
Full-time special class
LEVEL V
Special stations
LEVEL VI
Homebound and Hospitalized
LEVEL VII
Instruction in Residential or Institutional settings *
"IN-PATIENT" PROGRAMS (Assignment of children to facilities governed by health or welfare agencies)
"Noneducational" service (medical and welfare care and supervision)

FIGURE 2. Description of Educational Programs.

- I. Regular school situations in which allowances are made for the individual differences of a typical school enrollment.
- Ia. Regular school situation in which child needs and is provided with supplementary services only; no basic modifications required in the school's instructional offerings; child educated in regular classroom.
- II. Regular school situation in which child requires some supplementary teaching in the regular classroom; child may require some modification in materials and procedures offered by the regular classroom teacher.
- IIa. Regular school situation in which child receives specialized supplementary teaching for example, in itinerant speech and hearing services, and integrated programs for the visually and hearing impaired.

III. Regular school situation in which child is enrolled and receives specialized instruction in a special day class; child may participate part-time with regular class pupils in selected subjects.

IV.–V. Special day class or school in which child receives full-time specialized instruction in separate facilities and programs.

VI. Home or hospital instruction for child who is unable to attend school.

VII. Residential situation as in the case of the schools for the blind and the deaf, or a residential school for the mentally retarded or the emotionally disturbed. Education is provided in addition to residential care.

II. The Problem of Educating Exceptional Children

One of the major conceptual problems to be faced when we attempt to provide quality special education is that of differentiating between those children and youth who are truly exceptional and those who because of their disadvantaged and deprived environments, enter the schools less well prepared than the schools would like. We must all be aware that there is a population of socially disadvantaged pupils who share such characteristics as low economic status, low social status, low educational achievement, and limited ready potential for upward mobility. Their plight in the present educational system is quite well known. They are essentially normal pupils who are cause for much concern since their learning and adjustment in school is acutely below teacher expectations. "As a consequence, these children show in school disproportionately high rates of social maladjustment, behavioral disturbance, physical disability, academic retardation, and mental subnormality." (Gordon, 1968) These same children become ready targets of the referral process which would ultimately classify them as exceptional and place them in special education, when in fact they reflect only the environment which renders them incapable of experiencing what the school has to offer. This is far different from being exceptional in the sense of requiring special education because of an impairment or disability. This is the problem of *proper identification* of impaired, disabled, and handicapped children and youth.

One major procedural problem has been the extensive study of special education in the District. There have been a series of good studies, each producing a set of recommendations. The Working Party, The Passow Report, and the Executive Study Group reports all contain substantive reform measures, many which remain applicable even today. *Implementation* is what is required. We in the present administration are indeed fortunate to have these works as reference for our own efforts. We must now move toward implementation and providing fiscal allocations which will permit services to begin.

It is also noteworthy that several "no-cost" recommendations have been carried out within the past 90 days to provide for increased administrative coordination and to initiate procedures for accountability within the Department of Special Education. Several of these changes have served to highlight the need for increased fiscal resources but others have shown us clearly that quality education is a complex entity, a part of which is adequate financing. Other factors, including a high motivation among teachers for achievement, pride in a job well done, and stringent evaluation of each person's performance in line with the behavioral objectives of the Department are quite important.

There are three overriding problems which are addressed in this report on needs.

One factor which has become quite clear within the past 90 days is that improvement in special education in the District of Columbia is not simply to be obtained by providing more classes for or more direct services to exceptional children. The problems are seriously compounded by poverty, oppression, and bureaucracy. Most severe of all is a crisis of public confidence in special education: its leadership *and* services. This serious matter must be addressed through decisive policy and administrative action designed to rebuild the public trust and to insure to each and every parent suitable placement and quality education for his impaired, disabled, or handicapped child. This is the problem of *quality.*

There must be an immediate concern for unmet service needs. That is, the problem of providing a continuum of special educational services which will insure adequate psycho-educational assessment and individualized instruction for each pupil, arranged in a careful and efficient sequence so that every identified child has a place guaranteed for him. This is the problem of *scope.*

There must be the establishment of a set of interlocking counterparts which will permit an integrated sequence of administrative, instructional, and ancillary activities, all functioning smoothly on behalf of impaired, disabled, and handicapped children. This is the problem of *coordination.*

The major issues before the Department of Special Education at this time are those which involve *quality* performance in the public eye, *scope* of services available, and *coordination* of activities into a smoothly functioning organization. The following list summarizes the specific problems which must be faced.

ISSUE: Quality Special Education in the District of Columbia
- a. Leadership must be developed
- b. Level of instruction is below acceptable standards
- c. Few trained supervisors and educational specialists
- d. Inadequate assessment of children
- e. Many children misplaced
- f. Criteria for placement not explicit
- g. Early identification program lacking
- h. Basic classroom equipment lacking; space and supplies deficient

ISSUE: Scope of Special Education in the District of Columbia
- a. Parents not considered part of teaching transaction
- b. Containment—segregated model being utilized
- c. No follow-up on pupils
- d. Special activity programs (art, music, PE) undeveloped
- e. Lack substitute corps
- f. Number of teachers, aides, clerical and supervision personnel inadequate to task
- g. Transportation aides lacking

ISSUE: Coordination of Special Education in the District of Columbia
- a. No systematic prevalence study
- b. Recruitment is sparse
- c. No advanced level, publically supported training in D.C. area
- d. High mobility among students
- e. Communication with other agencies and private schools is minimal

From this list we have formulated those general needs of the department. They are listed below:

1. Quality Needs:
—active involvement toward raising the level of expectations among staff
—series of efforts to assure confidence of parents and community
—personalized supervision for all staff members
—re-training, training and staff development in fundamental principles of education and special education
—improvement in the trainable mentally retarded program

2. Scope Needs:
—expansion of programs and facilities
—set of basic classroom equipment for each special education teacher
—program for the educable mentally retarded child
—program for emotionally disturbed children and youth

3. Coordination Needs:
—strong liaison with administrative services department
—placement and re-entry agreement with Department of Human Resources
—central record keeping system for special education pupils
—liaison with other youth activity programs
—recruitment program in personnel department

There can be no doubt that serious steps must be initiated to simultaneously provide resolution for each of the three issues cited. Further, there must be careful attention to measures which will insure even development where problem areas exist. For instance, we cannot increase number of children in special education services without simultaneous expansion of management, instructional staff supervision, instructional materials, and transportation. Any major thrust to increase scope must be preceded by a comprehensive plan, adequately trained staff, and a system of accountability, all now in early stages of development in the Department of Special Education.

Quality can be achieved and in view of the seriousness of the problem certain recommendations for training and staff development will be put forth. Scope can be increased and certain recommendations for services and programs by category will be put forth, including the establishment of a reimbursement formula based upon identification of impaired, disabled, and handicapped children.

Coordination can be achieved and certain recommendations for interdepartmental liaison and for specific services to the Department of Special Education will be put forth.

The major objective we must all seek is to provide those dimensions of quality, scope, and coordination which will permit the re-establishment of public trust in our services, by what we do rather than by what we say. Swift policy making and administrative action is the order of the day and is the fundamental step now needed to insure that all impaired, disabled, and handicapped children between the ages of 3 and 21 receive adequate special education in the District of Columbia.

III. Cost Analysis Procedure

A cost analysis is appropriate to our problem in the District. The financing of programs is a matter of extensive public interest and professional study. Only recently have there been specific procedures for determining how funds should be allocated for handicapped children. An empirical method for determining the additional costs of educating handicapped children has come into wide use. Most governmental units and policy groups now accept some *formula* for determining why programs for exceptional children costs more. Cost differential is an accepted notion and a particular method has been utilized in this report.

Cost differential figures were obtained from the major educational authority on this matter. The Rossmiller Report (August 1970) was a comprehensive study of programs and costs for educating exceptional children in selected school districts across the United States, including one city comparable by population to the District.

The study is extensive and provides, as one of its findings, empirical data on costs associated with educational programs for special education, costs by program category, and projections on the cost of educating exceptional children in 1980. The Rossmiller Report is recognized as a major reference for identifying finance configurations and a *cost index* which would permit sound fiscal planning and forecasting of needs, particularly at a time where budgetary focus is on PPBS methodology and cost benefit analysis as an evaluative device.

A cost differential index is applicable for long and short range planning. Factors considered in the index are:

1. Management
   1.1 administration
   1.2 clerical and secretarial
2. Instruction
   2.1 teachers
   2.2 teacher aides
3. Instructional Support
   3.1 supplies and equipment
   3.2 guidance and counseling
   3.3 in-service education
4. Institutional Operations
   4.1 operation and maintenance
   4.2 fringe benefits
   4.3 substitute and leave of absence
5. Services
   5.1 health
   5.2 food

Separate cost data with regard to cost of transportation per pupil transported and cost of capital outlay are *not* included within the index. The major focus in this report will be those factors which are directly in the hands of the Department of Special Education and cost estimates must further be refined to determine division of responsibility. There must be no doubt that these ancillary factors must be considered if comprehensive planning is to become a reality and if we are to realize an integrated, coordinated system for the education of exceptional children.

Use of the Special Education Cost Index

The Rossmiller cost differential index by category of exceptionality is shown in Table 1. The index figure represents the difference per pupil for the exceptional child. When multiplied by the per pupil expenditure for regular pupils, a cost for the exceptional child can be obtained.

For instance:

The cost index for a Blind child is 2.97. This index is multiplied by the regular per pupil cost of $976 to obtain the cost of educating a Blind child as shown here:

index	2. 97
per pupil cost	×$976
cost of education for a Blind child	$2898.72

Thus, it costs $1,922.72 more to educate a visually impaired child than a normal child. Similar differential figures can be obtained for all exceptionalities and are shown in Table 2.

This method of computing costs is utilized throughout the report. It is considered to be a stable method for determining amount of funds needed to provide quality special education.

One fact which is quite clear from the tables is that we are presently spending less for our present special education program than we should be to adequately educate the students. According to the cost analysis procedure our current per pupil expenditure is $2,313.13. The cost index method tells us that we should be spending $2,371.18, a difference of $58.05 per pupil. This important finding has consequences for the quality of our programming and provides a sound estimate of needed additional funds per pupil. Quality special education requires that we close this financial gap in our existing program.

TABLE 1.—COST DIFFERENTIAL INDEX FOR EXCEPTIONAL CHILDREN

Category of Exceptionality:	*Cost Index*
Educable Mentally Retarded (EMR)	1. 87
Trainable Mentally Retarded (TMR)	2. 10
Emotionally Disturbed (ED)	2. 83
Specific Learning Disabilities (SLD)	2. 16
Crippled and Health Impaired (C, OHI)	3. 64
Hearing Impaired (HI)	2. 99
Visually Impaired (VI)	2. 97
Multiply Handicapped (MH)	2. 73
Homebound/Hospital (HH)	1. 42

—D.C. Per Pupil Expenditure for Special Education 1972 Estimate by Budget Department

Per pupil expenditure:	*Cost index*
Regular	$976. 00
Special education	2, 313. 13

This figure was obtained by removing special education expenditures from the citywide per pupil costs of $1,162 and re-computing the regular program per pupil cost ($976).

TABLE 2.—COST PER INDIVIDUAL PUPIL IN VARIOUS CATEGORIES OF EXCEPTIONALITY AS COMPARED TO AVERAGE PER PUPIL EXPENDITURE OF $976

Exceptionality	Cost index	Cost per exceptional child	Additional cost
EMR	1. 87	$1, 825	$849
TMR	2. 10	2, 050	1, 074
ED	2. 83	2, 762	1, 786
SLD	2. 16	2, 108	1, 132
C, OHI	3. 64	3, 553	2, 577
HI	2. 99	2, 918	1, 942
VI	2. 97	2, 899	1, 923
MH	2. 73	2, 664	1, 688

Note: Average cost to educate an exceptional child in the District of Columbia equals $2,371.18.

IV. Unmet Needs: Children and Youth Now in Special Education and the Waiting Children

The history of special education in D.C. has been one of late development, uneven growth, and constant pressure to do more with limited resources. Thus, quality of programming has suffered. Children now in special education programs are inadequately served because sufficient funds have not been made available.

Our first cost analysis and recommendations have to do with obtaining the proper amount of funds to insure a quality improvement for those children now in existing special education programs. While many may consider that the present funding level provides the proper quality of services, we have reason to suspect that it does not and that a supplemental allocation is needed to bring the present program up to acceptable funding standards. Table 3 shows the number of children presently receiving special education services from the adjusted FY 72 operating budget figure of $6,994,900.

TABLE 3.—NUMBER OF SPECIAL EDUCATION STUDENTS RECEIVING SERVICES

Exceptionality	District programs	Tuition grants	Total
EMR	103		103
TMR	586	130	716
ED	569	79	648
SLD	96	30	126
C,OHI	228	10	238
HI	58	184	242
VI	23	40	63
MH		32	32
Home/hospital	345		345
MIND	2,250		2,250
Total	4,258	505	4,763

By using the Rossmiller cost index the cost of providing quality special education services can be computed.

Table 4 provides that information by exceptionality. Because of the separate allocation to the tuition grant program per pupil costs for those 505 children were not computed. The MIND program allocation was also handled separately. Thus, Table 4 gives the amount of funds which should be available to provide quality special education for pupils now attending District services.

It requires $7,061,396 to hold the line and to achieve quality in the present program. This is $66,496 below the current $6,994,900 for FY 1972.

It is recommended that a special allocation of $66,500 be sought to provide the present special education program with a justifiable qualitative increase.

TABLE 4.—COST FOR CHILDREN NOW IN SPECIAL EDUCATION PROGRAMS, EXCLUDING TUITION GRANTS AND MIND

Exceptionality	Cost per pupil	Pupils	Total cost
EMR	$1,825	103	$187,975
TMR	2,050	586	1,201,300
ED	2,762	569	1,571,578
SLD	2,108	96	202,368
C, OHI	3,553	228	810,084
HI	2,918	58	169,244
VI	2,899	23	66,677
MH	2,664	0	
Home/hospital	1,386	345	478,170
Total		2,008	4,687,396
Tuition grant program		505	1,300,000
MIND program		2,250	1,074,000
Total		4,763	7,061,396

Unmet Needs: The Waiting Children

It is well known that active referral and testing has taken place within the District schools. The Department of Pupil Personnel Services provides a system for identifying more children than current placement stations can manage. Recommendations for special education placement either in the District program or through tuition grants far exceeds the present program capacity. While there can be a challenge to the validity of the entire assessment and recommendation process it is nevertheless known that identification and assessment are adequate but that placement is lacking.

There is a large number of children waiting for placement and immediate relief is necessary. The next analysis provides data on that need.

A detailed school by school survey of elementary age children who have been recommended for special education was recently completed. This information along with the numbers of children who have been recommended for tuition grants and for whom funds are not currently available is presented in Table 5. This table reveals what is known as "the waiting list" for special education services by exceptionality. There were, as of the week of September 27, 1971, 1,501 children who require special education services and are not now receiving them. Most are attending regular elementary school programs.

No data are available for adolescents or for those children and youth who are not now enrolled in a D. C. public school.

Table 6 shows the cost of providing services which are urgently needed for those children who require special education. These dollar amounts will provide services and programs *within* the District for all 1,501 children rather than the more costly and controversial tuition grant effort.

The total amount required is $3,502,052 with particularly large allocations for programs which now have a limited scope and require major expansion.

IT IS RECOMMENDED THAT A SPECIAL ALLOCATION OF $3.5 MILLION DOLLARS BE SOUGHT TO PROVIDE SPECIAL EDUCATION SERVICES TO THOSE CHILDREN NOW NOT RECEIVING THEM.

TABLE 5.—DIAGNOSED PUPILS RECOMMENDED FOR SPECIAL EDUCATION BUT NOT PLACED

Pupil personnel recommendation	Elementary school survey, Sept. 27, 1971	Tuition grants	Total
EMR	177		177
TMR	92	169	261
ED	223	283	506
SLD	329	85	414
C, OHI	12		12
HI	15		15
VI	6		6
MH	3	28	31
General special education	79		79
Total	936	565	1, 501

TABLE 6.—COST OF PROVIDING SERVICES TO WAITING, LIST CHILDREN, ELEMENTARY

Exceptionality	Cost per pupil	Number of pupils	Total cost for program
EMR	$1, 825	177	$323, 025
TMR	2, 050	261	535, 050
ED	2, 762	506	1, 397, 572
SLD	2, 108	414	872, 712
C,OHI	3, 553	12	42, 636
HI	2, 918	15	43, 770
VI	2, 899	6	17, 394
MH	2, 664	31	82, 584
General special education	2, 371	79	187, 309
Total		1, 501	3, 502, 052

Summary:

Costs required to provide quality special education to those children now being served and to those children who have been recommended but for whom placements are not available, have been computed. They are:

	Millions
Existing Program Requirement	$7. 061
1501 Identified Children	3. 502
Total required to provide for minimal needs	10. 563
FY 1972 Budget Request	6. 995
Additional Funds Required	3. 568

V. PROGRAM AND SERVICES NEEDS

[This chart presents a detailed picture of services now available and those needed. The total amount required for new sites is estimated to be $6,600,000. The total amount required to provide quality special education, as of this date, is $10,600,000]

Exceptionality	Number children requiring service		Personnel program				Personnel schools management		Sites		Funds	
			Present		Needed							
	Present	Waiting	Inst.	Mgt.	Inst.	Mgt.	Present	Needed	Present	Needed	Present existing program requirement	Needed (includes waiting)
Transitional/Educable Mentally Retarded: Full-time special classes. Ratio 15:1	103	177	7		18	1 Ed. Spec.			Classes in host schools.		$187, 975	$511, 000
Trainable Mentally Retarded: Full-time special classes. Ratio 12:1.	586	92	57	2 Ed. Spec.	70	1 Sup. Dir., 2 Sup., 2 Ed. Spec., 8 Resource Teachers.	1 Prin., 1 Asst. Prin. (Lee).	5 Prin., 4 Asst. Prin.	Pierce, Lenox Annex, Military Rd., Richardson Annex, Mamie D. Lee, 26 classes in host schools.	1 New Center at $1.400,000, 3 Primary Centers at $1,000,000, 1 Early Childhood Center at $800,000.	1, 201, 300	1, 736, 350
Profoundly Mentally Retarded: Full-time special classes. Ratio 8:1.	17	57	2		8				Special experimental program at Sharpe Health School. Additional classes will be located in Center with Health Services.	Special experimental program at Sharpe Health School. Additional classes will be located in Center with Health Services.	(2)	142,002
Emotionally Disturbed: Therapeutic Centers. Ratio 8:1.	569	223	50	1 Asst. Dir.	146	1 Sup. Dir., 2 Sup., 2 Ed. Spec.	1 Prin. (Boys)	1 Asst. Prin.	Boys Jr.-Sr. High School, Social Adjustment Classes in Host Schools.	Replacement for Boys Jr.-Sr. High at $1,200,000, 5 Centers at $200,000 ea.	1, 571, 578	2, 969, 150
Children with specific learning disabilities: Full-time special Learning centers.classes. Itinerant teacher program. Ratio 8:1.	96	329	8	1 Ed. Spec.	63	2 Sup., 2 Ed. Spec.		1 Prin., Asst. Prin.	Classes in host schools.	Multienvironment school at $1,200,000.	202, 368	1, 075, 080
Crippled and other health impaired. Ratio 9:1.	228	12	25		(3)		1 Prin., 1 Asst. Prin. (Sharpe).	1 Asst. Prin.	Sharpe Health School.	Existing facility used to capacity.	810, 084	852, 720

Hearing impaired: Full time special classes. Ratio 7:1.	58	15	5		8	1 Ed. Spec.	Classes in Grant School.	Full utilization of existing sites.	169, 244	213, 014
Visually impaired: Full-time special classes. Ratio 7:1.	23	6	9	1 Ed. Spec.	10		Classes in Jackson School and in host schools.	Full utilization of existing sites.	66, 677	84, 071
Multiply handicapped: Full-time special classes. Ratio 7:1.		8			1			Classes in host schools.		82, 584
Home/Hospital service as needed.	345		25	1 Sup.	(3)		In homes and hospitals.	MIND+Tuition.	478, 170	552, 117
									4, 687, 396	8, 218, 088
							MIND+Tuition.		2, 374, 000	2, 374, 000
Total.									7, 061, 396	10, 592, 068

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[1] Waiting list figures obtained by school to school check of DPPS recommendations (Elementary Schools).

[2] Nonbudgeted program cost absorbed by pooling funds.

[3] No additional.

VI. The Total Estimated Unmet Need

Any attempt to specify unmet needs for all children rquires some degree of speculation. One thing is certain, we do need to determine what our future efforts must be to properly educate exceptional children. There will continue to be a need for a continuum of services to these children and youth. While there will be substantive improvements in the quality of living for many persons, while technology will perhaps make education more skillful, and perhaps medical research and early childhood intervention programs will help prevent handicapping conditions, we will still be required to expend additional funds to educate exceptional children, including the gifted.

We would hope that the future holds forth an extensive early childhood intervention programs, which in the long run will have a preventative effect. Nevertheless, we do need some method for predicting future need. One such approach is by calculating the incidence of exceptionalities in the school age population.

This approach is well established as a guideline for special education needs. While the actual total of exceptional children can only be obtained by direct census, specific program planning can take place based on an estimate of the occurrence of a specific exceptionality in the total population. This method is utilized by the Council for Exceptional Children and the U.S. Office of Education in determining estimates for allocation of personnel and funds for special education. It is likewise appropriate that D.C. Public Schools use this base line data for its planning. The ability to plan, based upon incidence data far outweighs the extensive effort which would be required to complete an actual census, although a strong identification (early and on-going) does serve as a first step in determining actual incidence.

Incidence statistics provide as sound a procedure now available for determining need. Need is directly related to finance and it is from this point of view that we present a substantive cost analysis.

Table 7 shows the estimated number of exceptional children in the District of Columbia, according to an incidence formula provided by the Bureau for Education of The Handicapped—USOE.

This data current to the present school age population. There is an estimated 18,296 children currently living in D.C. who require special education services.

TABLE 7.—ESTIMATES OF THE INCIDENCE OF EXCEPTIONAL CHILDREN OF SCHOOL AGE

Exceptionality	Percent estimate	Estimated number of children in the District of Columbia
Mentally retarded	2.3	
Educable		7,776
Trainable		1,516
Emotionally disturbed	2.0	3,280
Specific learning disabilities	1.0	2,036
Crippled, other health impaired	.5	882
Hearing impaired	.575	428
Visually impaired	.1	164
Multiply-handicapped	NA	2,274
Total		18,296

It is important to consider that these estimates are in no way to represent a permanent state of need but provide a contingency plan for the establishment of a continuum of services and an organizational plan for determining the scope of services to be made available.

A cost estimate utilizing today's per pupil expenditure has been computed and is shown in Table 8.

TABLE 8.—IDEAL COST FOR TOTAL INCIDENCE OF EXCEPTIONALITIES IN THE DISTRICT OF COLUMBIA

Exceptionality	Total incidence	Cost per pupil	Ideal total cost
EMR	7,776	$1,825	$14,191,200
TMR	1,516	2,050	3,107,800
ED	3,280	2,762	9,059,360
SLD	2,036	2,108	4,291,890
C, OHI	882	3,553	3,133,750
HI	428	2,918	1,248,900
VI	164	2,899	475,440
MH	2,274	2,664	6,057,940
Total	18,296		41,566,280

The cost estimate of $41.6 million is of course simply a prediction and that actual costs are affected by many other variables such as type of program to be offered, organizational arrangements, and the degree to which the exceptional child can be integrated with his non-exceptional peers. There is also the important fact that some programs are more costly than others. A program by program comparison for present, waiting, and total needs is presented in Table 9.

TABLE 9.—COSTS OF SPECIAL EDUCATION FOR PRESENT EXPANDED AND ESTIMATED NEED IN DISTRICT OF COLUMBIA IN MILLIONS

Exceptionality	Present program	Waiting children	Estimated need
EMR	$217,000	$323,025	$14,191,200
TMR	1,386,000	535,050	3,107,800
ED	1,814,000	1,397,572	9,059,360
SLD	233,000	872,712	4,291,890
C,OHI	935,000	42,636	3,133,750
HI	195,000	43,770	1,248,900
VI	76,000	17,394	475,440
MH		82,584	6,057,940
General special education	522,000	187,309	
Subtotal	5,408,000	3,502,052	41,566,280
MIND	1,074,000		
Tuition	1,300,000		
Total	7,782,000	3,502,052	41,566,280
Number of children	4,763	1,501	18,296

This amount of $41.6 million is the best estimate of how much will be required in an ideal situation where every child's special education need would be met.

VIII. Staff Development and Leadership Personnel: Special Needs

The unique mission of Special Education requires that the Department be engaged in a systematic pattern of re-training, training and staff development of the entire department. No single or isolated session will obviate the need for a comprehensive sequential twelve months plan. This need can only be met by a continuous mandated program of staff development for all staff during the academic year 1971–72 conducted in conjunction with a public institution of higher education.

Needs, recommendations and action statements for increased services and modifications of service in the Department of Special Education have been set forth. There should be no doubt that the issues which must be faced are serious and will require a level of personal responsibility and a degree of change seldom assumed in public school systems. Inherent in the needs are specific programs of staff development which will require a commitment which reaches beyond the current state of affairs. Staff development which seeks to impart attitudes, knowledge and skills is essential to the implementation of the Design for Achievement and is a requirement for the future of Special Education in Washington, D.C. Staff development which provides the opportunity for an undertrained, new Department of Special Education to accomplish its mission is absolutely essential. Special education, as a discipline, is fortunate to have many rich resources upon which to draw for staff development activities. What is required is planning, implementation, and feedback of results, and the allocation of funds and time. All are essential to the conduct of an effective staff development program.

The program will focus on the following:

1. Humanistic Education and the development of achievement motivation techniques:
   - —need for achievement
   - —need for affiliation
   - —need for power

This will be a specific training effort which will provide staff with an introduction to methods of phychological education, taking action, and learning to help which are basic to understanding the handicapped.

2. Curriculum Development and Pedagogy, including
   - —needs assessment
   - —the teaching of reading and mathematics to handicapped children
   - —creating realistic standards and expectations
   - —classroom management techniques
   - —use of behavioral objectives

This will be a specific training effort which will provide staff with an opportunity to build and apply basic psycho-educational assessment methods and the learning center philosophy.

Needs: Action Strategies and Cost

1. Create a position of Supervising Director for staff development. This position will encompass the area of preventative educational action programs	$17,500.00
2. Consultants Services	1,000.00
3. Create two clerical support positions:	
GS–5	7,631.00
GS–4	6,823.00
Total	32,954.00

4. Release all special education pupils on Thursdays at 1:00 p.m. during the school year to provide release time for all teaching and supervisory personnel to become involved in a sequential staff development program.
5. That all Federal funds for training be devoted to the staff development program and that additional funds be sought in conjunction with local university programs. Cooperation with the Staff Development Department and with Innovation Team is essential to accomplishment of this goal.

Staff development is the main priority for the 1971–72 school year. Our emphasis must be on inculcating knowledge, attitudes, and skills, but most importantly, on building morale and motivation to work toward collectively derived goals. In this regard, a major effort through staff development will be to build teams and instructional clusters where individuals learn from each other. A secondary effort will be to provide key staff with models of excellence, including the benefits of pooling skills and close supervision.

The development of a suitable administrative organization for special education is an important goal. The organizational plan for a large metropolitan area, in addition the Nation's Capital, should reflect a high degree of competence and professional expertise. The District's uniqueness as a state and local agency giving special education services to children from many countries and to many influential persons requires a strong administrative component.

Many new programs and services must be initiated, beyond the basic and fundamental effort. The future holds forth the need for bi-lingual staff, the development of an extensive parent involvement program, a nation-wide recruitment effort, a guidance program for exceptional children, and new efforts at insuring the rights of children through child advocacy programs.

Each of these internal increases in effectiveness requires proper, sensitive administration.

Effective coordination and direction of the services anticipated definitely requires additional major administrative positions. It is recommended that the following additional positions be established:

Director of Special Education, 2 additional positions	$40,000
Assistant Director of Special Education for Placement Services, 1 position	15,000
Transportation Coordinator	15,000
Administrative Aides:	
GS–8, 2 positions	20,000
GS–6, 4 positions	32,000
GS–4, 3 positions	15,000
Total Special Administrative Request	101,000

Emphasis must be placed on attracting persons with known administrative experience and leadership ability for the District's special education programs of the future. Nothing less can get the gigantic task accomplished.

VIII. General Recommendations

A. Future Oriented and Preventative in Nature

1. Programmatic

a. That support be given to quality improvements in special education through provision for adequate supervision, high teacher expectations, and parental involvement in the education of exceptional children and that specific staff changes take place.

b. That a system of reimbursement be formulated to insure that adequate resources are available for identified exceptional children. The reimbursement should be based upon a weighted formula multiplied against the additional total per pupil cost as the means for determining allocations for exceptional children.

c. That there be established an early identification system in the District of Columbia, including an extensive pre-school intervention program for children between the ages of 3 and 5.

d. That the Department of Special Education establish a network of learning centers for handicapped children so that learning and adjustment problems can be solved within the context integrated schooling rather than through self-contained special classes.

2. Financial

a. That there be established, from regularly budgeted funds a state planning office for special education programs. The function of this statewide office would be to engage in adequate needs assessment of pupils, coordinate delivery of services, and provide for systematic evaluation for all special education programs. Minimum allocation: $150,000 and 4 positions.

B. Immediate and Corrective in Nature

1. Programmatic

a. That the present MIND program be changed in nature and capability to meet the educational needs of the educable mentally retarded.

b. That the majority of funds available under Public Law 89–313 along with an allocation from Title III and Public Law 91–230 be set aside for an innovative quality improvement effort for trainable mentally retarded children.

c. That the authorized "set aside" of Title III Funds be utilized entirely for the initiation of plans and pilot program for a city-wide service for emotionally disturbed children and youth.

d. That impact aid funds be utilized to provide an immediate increase in administrative, clerical, supervisory and resource staff in the general special education program.

e. That 3% of the funds in the tuition grant program be allocated to staff positions which will provide efficient administration and supervision of that important program.

2. Financial

a. That a special appropriation be sought to provide planning, implementation, and special educational programming for educable mentally children in the District of Columbia. Allocation: $65,000 and 3 positions.

b. That a special appropriation be sought to establish a central record keeping system for the Department of Special Education and to adequately staff a central registry system. Allocation: $32,000 and 2 positions.

c. That a special appropriation be sought to provide basic instructional equipment in every existing special education classroom at a cost of 1,000 per classroom. Total allocation $175,000.

d. That a special appropriation be sought to adequately support the Special Education Materials and Media Center so that services will readily be available to all teachers. Allocation: $175,000 and six positions.

IX. References

1. Rossmiller, R. A., Hale, J. A. and Frohreich, L. E. *Educational Programs for Exceptional Children: Resource Configurations and Costs.* National Educational Finance Project Special Study No. 2.
2. *Facts and Figures 1970–71.* Public Schools of the District of Columbia, Washington, D.C.

3. *A Design for a Continuum of Special Education Services.* Division of Instruction, Maryland State Department of Instruction, June 1969.
4. *Toward Creating a Model Urban School System:* A study of the Washington, D.C. Public Schools. 1967.
5. *Crisis in Child Mental Health: Challenge for the 70's.* Report of the Joint Commission on Mental Health of Children, 1970.
6. Tannenbaum, A. J. (ed.) *Special Education Programs for Disadvantaged Children and Youth.* Council for Exceptional Children, 1968. Chapter I: "A View of the Target Population" by Edmund W. Gordon.

SUMMARY OF FISCAL RECOMMENDATION

A. Qualitative Increase:	
1. Services	$66,496
2. Staff Development	32,954
3. Leadership	101,000
4. Planning Office	150,000
5. EMR Staff	65,000
6. Central Record System	32,000
7. Basic Classroom Equipment	175,000
8. Materials & Media Center	175,000
Total	797,450
B. Unmet Need—1,501 children	3,402,052
C. Estimated Total—Unmet Need	41,566,280

PRELIMINARY FACT SHEETS FOR DISTRICT OF COLUMBIA COMMITTEE,
HOUSE OF REPRESENTATIVES

JOHN L. MCMILLAN, *Chairman*

D.C. MENTAL HEALTH ASSOCIATION

for

HEARING ON NEEDS OF MENTALLY ILL CHILDREN IN D.C.

Tuesday, March 14, 1972, 10:30 A.M.

Descriptions Included

(1) The D.C. Mental Health Association
(2) Mentally Ill Children
(3) Residential Psychiatric Treatment Program
(4) Special Education

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(1) DESCRIPTION OF D.C. MENTAL HEALTH ASSOCIATION

The D.C. Mental Health Association is a voluntary citizens' organization incorporated in 1953 for the following purposes:

To improve the care and treatment of the mentally ill
To improve methods in prevention, diagnosis and research
To promote mental health

Programs to fulfill these purposes and to improve the quality of life in D. C. are carried out through direct services and social action. Examples:

. . . social work and community service to 200 adult former mental patients living in foster homes
. . . job-finding for former mental patients
. . . volunteer service at St. Elizabeth's Hospital
. . . public education
. . . promotion of mental health careers among high school students
. . . information and referral services
. . . assistance to public and private agencies in planning mental health programs
. . . monitoring public budgets, laws, regulations and administrative procedures affecting the mentally ill and their families
. . . study of amount and quality of services and dissemination of facts
. . . development of demonstration projects; e.g., the Child Learning Center for Pre-School Children in Foster Care

The Association is a United Givers Fund agency and a Division of the National Association for Mental Health.

(2) DESCRIPTIONS OF MENTALLY ILL AND EMOTIONALLY DISTURBED CHILDREN

Two descriptions of emotional disturbance are presented to indicate the range of considerations involved.

The first is from "The Needs of Exceptional Children in the District of Columbia," a report prepared by the Department of Special Education:

"Seriously emotionally disturbed individuals exhibit one or more of the following characteristics over a long period of time and to a marked degree:

(1) Inability to learn that cannot be explained by intellectual, sensory or health factors.
(2) Inability to build or maintain satisfactory interpersonal relationships.
(3) Inappropriate behaviour or feelings.
(4) General pervasive mood of unhappiness or depression.
(5) Tendency to develop physical symptoms, pains or fears associated with personal or school problems.

The second description is taken from material to be presented to the House District Committee on March 14:

"An emotionally disturbed child is one who has difficulty in coping with his life; his personality development has been interfered with by factors in his environment. He seems immature for his age and there is a lag in his intellectual potential, *which may be normal or higher.* He may interact in an unacceptable way with his peers. He may have temper tantrums and crying spells; perhaps at times he bangs his head against the wall unceasingly; or he may walk on all fours and bark like a dog; or he may only relate to a tree, not to his mother or teacher; or he may withdraw inside himself and refuse to communicate with human beings; he has difficulty in controlling his impulses and difficulty in learning. And those who are most severely ill may try to kill themselves and/or others.

(3) DESCRIPTION OF RESIDENTIAL PSYCHIATRIC TREATMENT PROGRAM

Residential treatment is essentially a therapetutic milieu in a facility which provides corrective life experiences to counteract the damaging and painful experiences which led to the child's emotional disturbance. It provides a variety of programs that include different forms of individual and group therapy, education, nursing care and the other kinds of care required for 24-hour living. Treatment takes place within a consistent, planned environment. It requires a staff of skilled personnel, trained and experienced in working with children and able to collaborate in a complex and highly varied program.

This treatment also requires collaborating with people close to the child; such as, parents, other family members and teachers. It should often include supportive therapy with the family.

This 24-hour program must be part of a carefully constructed comprehensive continuum of services as close to the child's home as possible.

The facility in which the program is provided should be small enough (20 beds) to provide a non-institutional atmosphere and individual attention. Such a facility can serve (when out-patient and day-night care is included) up to 100 children.

(4) DESCRIPTION OF SPECIAL EDUCATION*

Special Education is that part of education which devotes its attention to students who, after a professional evaluation and/or appraisal, are considered to exhibit one or a combination of the following:

impairment: defective bodily structure (senses, systems, organs, members, etc.)

disability: a limitation of activity when compared with other individuals of similar age, sex and culture.

handicap: a reduction of personal or social efficiency and the stigma therefrom.

These pupils are generally known as "exceptional" in terms of the usual manner of classifying human problems. *A Department of Special Education exists for the purpose of educating those children who are exceptional physically, mentally or emotionally to the extent that they require special educational services in order to develop to their maximum capacity.*

Special Education, in practice, concerns itself with:

(a) an altered instructional environment which will attend itself to the educationally significant attributes of the student's condition.

(b) Specialized materials and methods of instruction.

(c) Provision for the interweaving of non-educational therapeutic procedures into an educational process.

(d) Teachers with specialized training in education of exceptional children and the temperament to carry out their unique role.

Special educational methods and techniques provide for instruction of children in subject and content but with cognition, perception, language, emotions and social forces as constant criterion variables which each teacher must know, monitor and teach to, in a personalized form of instruction.

Mr. Fowler. Our other request, sir, is if you would keep the record open for ten days, we would like to submit some additional material, material specifically in respect to what Mr. Abernethy——

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*From "Needs of Exceptional Children in the District of Columbia," prepared by staff of the Department of Special Education, D.C. Public Schools, October, 1971.

Mr. McMillan. Without objection, and I'd like to say to you, Mrs. Bregman, I think, if it's necessary for any legislation, we'd be happy to introduce it. In fact, every member will be happy to go on this Bill as a sponsor.

Mrs. Bregman. Thank you very much, Mr. Chairman, that's very gratifying.

Mr. McMillan. Do you have any other people you would like to have speak before we adjourn?

Mr. Fowler. We have Dr. Lourie.

Dr. Lourie. Reginald Lourie, Department of Psychiatry, Children's Hospital and Director of the Oak Crest Children's Center.

I think maybe one answer to the question of manpower might be looked at in terms of the number of child psychiatrists that were here twenty-five years ago when I first came to this town. There were two trained child psychiatrists. There are now a little over one hundred.

So that we have probably the largest, fastest growing new specialty in the field of medicine, and paralleled with this grows a whole range of related professionals who work with us and possibly the best way I could respond to what has been talked about is to put it into the form of a story, one about three men sitting on a river bank fishing and in current of the river there are a couple of children floating, struggling, and they are going to drown if nobody gets to them.

These men form a team, wade out and they get those children, but before they get them, there are five more floating down the river in the current, and they wade out and get those, but before they get those, they are ten more and they are hauling and pulling, and lots of the children are getting away from them, and one fellow quits and he starts walking up stream and the other two yell to him, get back here; can't you see all the work we've got to do?

And the first fellow says, the devil with that, I'm going up around the river bank and get the guys that are pushing them in.

So that we need the haulers and the pullers and with a variety of tools to work with, but we also need those people who are going to follow the man going around the river bank doing the preventive work that the third recommendation you heard today would make available.

Mr. McMillan. Thank you very much. The various documents and exhibits which you have brought with you will, without objection, be included in the record. (See Appendix).

Dr. Allen, would you care to make a brief statement before we adjourn?

STATEMENT OF DR. LEONARD ALLEN, CHIEF, BUREAU OF DEVELOPMENT DISABILITY, D.C. MENTAL HEALTH ADMINISTRATION

Dr. Allen. My name is Leonard Allen, I'm with the Mental Health Administration, and I don't believe there's very much I can add to the statement Mrs. Bregman has made and Dr. Lourie has made.

I would like to emphasize, however, the report that Dr. Lourie has so eloquently demonstrated in his story, that our concern is basically with prevention.

We are concerned with cure; we are concerned with treatment but prevention is our primary interest, and the need here lies not just in additional psychologists and psychiatrist and social workers and teachers, but better housing, better schools, better opportunities for people to grow up in an environment which is not conducive to the developments of kinds of problems which we are faced with.

Thank you, Mr. Chairman.

Mr. McMillan. Thank you very much.

Mr. Fowler. Mr. Chairman, Mr. John L. Johnson who is associate superintendent for special education in the D.C. schools would like to make just a brief statement.

Mr. Johnson. Thank you, Mr. Chairman, and members of the Committee.

I would emphasize the points already made in the testimony, that is, the part of the treatment of any child who is emotionally disturbed and mentally ill is that he has a right to public supported education suited to his needs.

The public schools in the District of Columbia, particularly in the public education department, as one of the newest departments has a gigantic responsibility to attempt to meet the needs of the more than 1500 children we know of and to build and develop a system of services which helps to prevent the kinds of problems we are here today speaking of.

My own particular field of expertise in special education began as a teacher in a psychiatric hospital and in working in child guidance clinics and having served as the Vice President of the Michigan Association for Emotionally Disturbed Children, I have a fairly intimate knowledge of the kinds of programs which are necessary, and the testimony that has been presented here today is a cooperative testimony and we're hopeful that the Committee and any other agencies and organizations of government officials will see to it that the needs of our children who are disturbed are met and that the services are provided.

Thank you.

Mr. McMillan. Thank you.

I'm certain that every member of this Committee is very sympathetic to the fine work that you people are doing and we want to cooperate in sponsoring legislation to this effect.

Mr. Fowler. Thank you, Mr. Chairman. We'd like to thank you once again for your attention and interest this morning.

Mr. McMillan. The Committee is adjourned.

(Whereupon, at 12 p.m., the hearing in the above-entitled matter was adjourned.)

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

"Report of the Joint Commission on Mental Health of Children, Inc."—1969 pp. 0398–0475, Chapter VI, "Emotionally Disturbed and Mentally Ill Children and Youth" (Harper & Row, Inc., 49 East 33rd Street, New York, N.Y. 10016)

U.S. Bureau of the Census, *Current Population Reports*, Series P–60, No. 53, "Income in 1966 of Families and Persons in the United States," Washington, D.C.: U.S. Government Printing Office, 1967, p. 28.

U.S. Department of Health, Education, and Welfare, "America's Children and Youth in Institutions: 1950–1960–1964," *Children's Bureau Publication*, No. 435, 1965.

U.S. Senate, Subcommittee on Employment, Manpower, and Poverty of the Committee on Labor and Public Welfare, *Hunger and Malnutrition in America* (90th Congress, 1st session on Hunger and Malnutrition in America, July 11 and 12), Washington, D.C.: U.S. Government Printing Office, 1967.

Werkman, S., Shifman, L. and Skelly, T., "Psychosocial Correlates of Iron Deficiency Anemia in Early Childhood," *Psychosomatic Medicine*, No. 26, 1964, pp. 125–34.

Yamamoto, J., Quinton, C., Bloombaum, M. and Hattem, J., "Racial Factors in Patient Selection," *American Journal of Psychiatry*, *124*, 5, 1967, pp. 84–90.

CHAPTER VI—EMOTIONALLY DISTURBED AND MENTALLY ILL CHILDREN AND YOUTH [1]

This chapter is specifically concerned with problems of mental illness and serious emotional disturbance of children and youth. The earlier chapters of this report were focused primarily on the programs that are needed in this country to prevent emotional and mental disorders and to promote mental health in our young population. Preventive programs have been emphasized along with programs that promote positive mental health, with positive mental health being defined as more than the absence of mental illness or severe emotional disabilities.

These programs are not seen as being in place of, or necessarily completely separate from, the other more massive, preventive programs that have been discussed previously in this report. Rather, they are seen as being chiefly more intensive and more specific in their emphasis on the provisions of pychiatric and related services for children and youth with severe problems of mental illness and emotional disturbance.

It is very probable that most, if not all, of these disabilities are an extreme manifestation of the universal difficulties that human beings encounter in the course of their growth and adaptation to the complex process of becoming effective, contended, contributing members of society. Thus, programs aimed at promoting positive mental health may, in part, serve more seriously handicapped youngsters, but general mental health and related services, by themselves, are usually inadequate to meet all the needs of the seriously afflicted. Thus, specialized programs must be added to those more general ones that have been espoused earlier in this report.

DEFINITIONS OF MENTAL ILLNESS AND EMOTIONAL DISTURBANCES

There is considerable confusion at present regarding the definition of mental illness and serious emotional disturbances. Many different diagnostic categories and ways of viewing the problem exist. This is related to the fact that child psychiatry and clinical psychology are rather new fields, and that the major emphases have been on treatment rather than research. Moreover, the search for clear, definitive understanding of emotional and mental disorders has proven to be exceptionally baffling and complex. A full discussion of these matters is out of place here—the American Psychiatric Association and other professional organizations are currently working towards more generally accepted and widely used systems of definition and diagnostic categories. A few of the current formulations will be presented in the pages that follow.

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[1] The subject of mental health manpower is not discussed in this Chapter. See Chapter XI.

For example, some authorities suggest that there are five major categories of emotional and mental disorders when they are viewed in terms of their origins. These categories are as follows: 1) faulty training and faulty life experiences, 2) surface conflicts between children and parents in reference to such adjustment tasks as relations between siblings, school, social, and sexual development, 3) deeper conflicts which become internalized within the self and create emotional conflicts within the child (these are so-called neuroses), 4) difficulties associated with physical handicaps and disorders, 5) difficulties associated with mental disorders (the psychoses). It is proposed that 80 percent of emotional problems are related to the first two categories; 10 percent to the third category; and 10 percent to the fourth and fifth. In reference to the first large group, highly trained mental health specialists are not required for handling these kinds of problems; rather such children can generally receive sufficient help from a variety of people who work with them, such as parents, teachers, public health and school nurses, etc.

Dr. Dane Prugh has worked out a system for diagnosing, classifying, and treating emotional and mental disorders. He ties this system primarily to the developmental stage of the child and the degree to which he is handicapped or suffering from dysfunction. Prugh sees mental health as being largely on a continuum, ranging from excellent to very poor psychosocial-physical functioning. His charts will be found in the Appendix of this chapter. This approach appears to be particularly promising.

The Committee on Child Psychiatry of the Group for the Advancement of Psychiatry proposes a classification system divided into the following main categories: healthy responses, reaction disorders, developmental deviations, psychoneurotic disorders, personality disorders, psychotic disorders, psychophysiologic disorders, brain syndromes, mental retardation, and other disorders.

This Committee also adlopted three basic propositions to the effect that a) there is a unity of mind and body and psychological and physical processes are closely inter-related, b) diagnosis must be related to the developmental stage of the child, and c) the child's behavior is deeply affected by his experiences in his family and the larger society. The Committee further stresses that a child's behavior is a product of multiple factors: physiological, psychological, and social, but concludes that, at the present, a classification system cannot take into account all of these factors in their great complexity and interaction.

Another approach, which might be termed social-psychological-educational, emphasizes that a child's behavioral difficulties are closely associated with gaps or deficits in his learning of social, behavioral, and academic skills as a result of failures and problems in his environment: family, school, and neighborhood.

Yet another approach to the definition and description of emotional disturbance, not fully developed at present, may be called the ecological or systems analysis of the problem. The child is seen as defining a small social system of which he is an integral part and which includes his home, school, neighborhood, and larger community. The behavior patterns of the child in the context of requirements and expectations of a particular social system may lead to acceptance and support of the child or to his rejection, to his being defined as "disturbed" or "delinquent" or perhaps "mentally retarded." A child is identified as emotionally distrubed when there is too much discord in the system, when there is an intolerable discrepancy between the behavior of the child and the expectations of the normal socializing institutions. This concept is increasingly a part of most classification systems. When taken seriously it leads to intervention that may include conventional psychotherapeutic procedures but would involve other strategies as well (Hobbs, 1966).

According to the Clinical Issues Committee Report, the emotional and mental illness problems of pre-school children may include:

1) Childhood psychoses which are the most serious forms of mental illness and which include such diagnostic categories as infantile autism and childhood schizophrenia;

2) Childhood neuroses which are characterized by such symptoms as extreme and unreasoning fears; continuing rituals carried out in a driven way; deep emotional depression; severe shyness and withdrawal from people and the environment; compulsive manipulation of parts of the self such as pulling of one's own hair, head rubbing, unceasing masturbation, and the like;

3) Children with minimal brain dysfunction who demonstrate such problems as physical awkwardness, hyperactivity, and learning disorders;

4) A large group of disturbances which lie in the area of behavioral problems. "The latter category includes the dangerous child, the child whose tantrums, lying, and destructiveness set him apart from other children from a very early age" (Clinical Issues Committee Report, 1969).

5) Children with sexual deviations which lead to confusion over their sex identity and various forms of perversion and unusual sex interest. "Some boys, for example, show marked feminine interests from age two or even younger, along with compulsive patterns of sexual activity."

6) The failure-to-thrive syndrome is an important and serious condition particularly found in some infants and young children. It reveals itself in the failure of some youngsters to grow and develop normally in the areas of physical, intellectual, and emotional development. This is becoming an increasingly widespread problem and its origins are incompletely understood, although at least some of these children appear to be products or neglecting or unusually cruel parents (Task Force II, 1969; see, also, Chapter V, Section I).

7) Children with physical or mental handicaps which are generally made more disabling because of the associated emotional reactions of both parents and children.

NATURE AND SCOPE OF PROBLEM

The Joint Commission has made the following definition of emotionally disturbed children: "An emotionally disturbed child is one whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment: 1) for reasonably accurate perception of the world around him; 2) for impulse control; 3) for satisfying and satisfactory relations with others; 4) for learning; or 5) any combination of these. This definition would seem to cover, in a general way, the major features of the various definitions which have been sketched here. In reviewing various treatment approaches, Gioscia and associates (1968) conclude that regardless of varying diagnostic and theoretical systems, the basic methods of treatment tend to be fairly similar in actual work with disturbed children and youth (see, also Chapter XII, Research). The goals of such treatment are generally tied to the criteria of mental health presented above.

Incidence of Mental and Emotional Disorders

Estimates vary as to the number of mentally ill (psychotic) children and young people in this country. It is estimated that about .6 percent are psychotic and another two to three percent are severely disturbed. It is further estimated that another eight to ten percent of our young people are afflicted with such serious emotional problems (neuroses and the like) that they are in need of specialized services. However, it appears that only about five to seven percent of the children in this country who need professional mental health care are getting it (Gioscia, *et. al.*, 1968; Task Force V, 1968). According to the best available figures, only about 500,000 children are currently being served by mental health facilities (clinics, hospitals, private therapists) but over 7,000,000 young people under age 24 need professional help.

As a nation, we do far better for our physically handicapped children than we do for those with emotional and mental handicaps. For example, it is estimate that 7.6 million children are in need of services for the physically handicapped and that 5.6 million receive such services (Task Force V, 1968). It is clear that the present dearth of mental health services will become more acute in the immediate future. The child and youth population is growing and there are indications that a larger proportion of this population will be in need of such services; for instance, since 1950, the number of boys under age 15 in the population has doubled but their number in mental institutions has quadrupled (NIMH, 1968).

Although mental health services for the population have been greatly expanded over the past 15 years or so, we are falling far short of our frequently announced national goals regarding a commitment to the youth of this nation. For instance, Dr. Rexford of the Boston University School of Medicine writes "Our national wishes and intentions to care adequately for emotionally disturbed children have been articulated repeatedly and with eloquence." For example, groups of citizens and government officials drew up the following statement at the 1930 White House Conference:

The emotionally disturbed child has a right:

(1) to grow up in a world which does not set him apart, which looks at him not with scorn or pity or ridicule—but which welcomes him, exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.

(2) to a life on which his handicap casts no shadow, but which is full day by day with those things which make it worthwhile, with comradeship, love, work, play,

laughter, and tears—a life in which these things bring continually increasing growth, richness, release of energies, joy in achievement.

There are in the United States: 2,500,000 children with well-marked behavior difficulties including the more serious mental and nervous disorders.

Even as early as four years of age, it has been shown that more than 35 percent of the apparently normal children of self-sustaining families, average intelligence, have detectable behavior difficulties.

A comprehensive program to prepare the emotionally handicapped child for life's work must include: early discovery and diagnosis which will determine the nature and extent of the handicap while it is in the incipient stages and when the greatest possible benefit may be secured from care and treatment.

Protective legislation which will make a comprehensive program for the handicapped fully effective, safeguarding the interests of the handicapped as well as the employer.

Research which will determine the fundamental causes of mental and physical disabilities and discover the most effective methods of prevention and control of all handicaps.

National and central state agencies which will provide for the integration of national, state, and local educational, vocational, industrial, health, and welfare activities in a comprehensive plan on behalf of the handicapped child.

"Have we really made headway during these 30 years, years during which we have attained the highest per capita income the United States and indeed the world has ever seen? We can note lamentably limited progress. What has been the cost to individual lives, what the waste to our nation of ignoring these recommendations? During 1967, the federal government appropriated $1.11 billion for cotton price support and one-twentieth that amount for child mental health services conceived in the broadest possible terms. What are our priorities? Do we indeed lavish care upon our children? What happens between the rousing statement of the child's bill of rights and the feeble, inadequate implementation of these goals?"

Dr. Rexford also comments: "A curious factor has emerged about the basis for this support. Certain public figures have given such an endeavor (mental health programs) their interest in 'cutting down crime in the streets' . . . The extent and seriousness of youthful anti-social behavior are cogent reasons for wishing to plan more effectively and to ameliorate mental disturbances in the young; the possibility that the youthful delinquent becomes a serious adult criminal is often borne out. It takes one aback, however, to be told that protection of society *from* its children in this direct sense is the compelling motivation of many influential citizens for programming for emotionally sick children and youth and those at high risks" (Rexford, 1969).

Our national failure to provide even minimally adequate services for the emotionally disturbed and psychotic children and youth in this country is related to many factors. One of them is the greater emphasis that is generally placed on providing programs for adults. For instance, special services required for children have not been included in many Community Mental Health Center programs. "The failure of the great majority of states to include *any* plans for children in mental health programs presented to the U.S. Public Health Service in 1963 led to the convening of a national conference that year on planning child psychiatric services within community mental health programs. However, the recent visit of a survey team to eight Comprehensive Mental Health Centers planned with and funded by the U.S. Public Health Service brought forth the distressing observation that only two had any kind of specific children's services and of these two instances, only one offered a satisfactory program. There were no plans in the other Centers to move ahead in providing appropriate children's services although these had been included in the original blueprints . . ." Moreover, "Many child guidance clinics are currently the nuclei for mental health center programs, their staff serving adult patients, their activities for children steadily declining.

Supposedly, this diversion from the children's program is temporary, but given staffing realities in many communities embarking upon a Center program, it may not be unlikely that less service for children will be available within so-called comprehensive programs than was provided for children previously. It appears that whenever in-patient beds must be allocated to adult or child services, the latter rarely receive precedence. You may say that it is clearly more important to have the bed for the adult patient, but is that true? Is the adult's depressive and suicidal status so obviously more significant than that of a 10 year old boy that no questions are raised about the decision? What of the suffering in the present? What of the important for the future?

'Who speaks for the sick children?' is a question which might echo across the country these days as the planners, citizens, and government agents sit down together (Rexford, 1969). The fundamental problem is not that adults are receiving too many mental health services; rather, the problem is basically that there is a severe shortage of mental health programs of all kinds for all age groups in the population. Children and young people are less well-served than adults, although no group is adequately served.

This appalling lack of services, especially in reference to children and young people, is extremely critical and short-sighted. The experience of psychotherapists and other clinical personnel in the mental health field strongly indicates that the roots of mental illness and severe emotional problems most usually extend far back into infancy and early childhood. In fact, many specialists in the field hold that the origins of most such disturbances are found in a combination of constitutional factors that are present in a child at birth, the effects of these factors on the feelings and attitudes of the child's parents (or other caretakers) and the consequent interaction between the infant and the significant people in his environment in the first few months of his life (Lourie, 1967). Most clinicians agree that an extremely important time for both remedial and preventive broadly defined mental health services is during the mother's pregnancy and the very early years of infancy and childhood (Clinical Issues Committee Report, 1969). (See, also, Chapter VII.)

Despite this concensus, the present tendency in the provision of mental health services, to the extent that such services are available at all, is to identify children in need of professional help and refer them for such help after they have reached the age of six or more and are found to present problems in school adjustment. There is considerable evidence, mostly derived from clinical practice and theory and from related observations (Pavenstadt, 1966; Minuchin, *et al*, 1967), that this is far too late for the most effective intervention in the child's basic adjustment. By the time he has reached this age, his personality may have become highly disorganized or set in rigid patterns that are not easily changed.

This is not to infer that late treatment is of little use; appropriate mental health services to children and youth of all ages may well be highly effective. The major point is that early intervention is likely to be the most helpful and may well prevent the cumulative compounding of the child's difficulties. This is especially likely to be the case if early services are followed by a wide range of supportive services to further aid and protect the child and young person at mental health risk. Moreover, such continuing services are needed because early treatment is not an assurance that symptoms of disorder will not appear at a later date (Clinical Issues Committee Report, 1969).

It is apparent that part of a greatly expanded investment in programs for the mental health of children and youth should be focused specifically on treatment, research, and training in the field of services for the mentally ill and emotionally disturbed children and youth of this country. It is also apparent that particular, but not sole, emphasis should be placed on programs for those infants and young children who are in danger of developing disabilities of these kinds. Further specific emphasis should be placed on the coordination of programs which are, at present, fragmented and, at times, overlapping.

Epidemiology

We simply do not know for sure how many emotionally disturbed and mentally ill children there are in this country. National epidemiological studies of mental illness have not been carried out. As already stated, it is generally estimated, on the basis of partial data, that from .6 to three percent of our children and youth suffer from psychoses and another eight to ten percent have severe emotional disturbances. Among disadvantaged pre-schoolers, observation indicates that about one-third may suffer from emotional or mental disabilities.

According to Rexford: "As a nation we have not been able to look honestly at the scope of the problem of emotional disturbance in children and youth nor at the size and quality of the resources available to cope with these children. We have not developed the systematic surveys, the categories of conditions, the conceptual models, nor the adequate reporting and analyzing systems to know where we are.

"However concerned we may be about the lacunae in our information regarding emotionally disturbed children identified by psychiatric facilities, the total situation may be far more serious. A large population of the children residing in correctional institutions, welfare homes, state schools, and foster homes undoubtably suffer from emotional and behavioral disturbances. They may be labeled dependent, neglected, delinquent, or retarded and there is no way under present circumstances to include them in a comprehensive mental health survey. Each grouping of institutions has its own nomenclature and its own programming. There are those who believe that the reform schools and correctional institutions of the country are the sites of the same kind of neglect of mentally disturbed young individuals as the state hospital back wards were of adults."

It should be borne in mind that, for every child who has a severe mental health problem, many more are affected—those who are in association with him in his neighborhood and in his school, but most especially the members of his family. In reference to families, alone, one could estimate that at least three other people—parents and brothers and sisters—are intimately and deeply affected by a child's mental illness or serious emotional disorder.

It is likely that the prevalence and severity of emotional disorders will become worse in the future. This is related both to the increasing size of the child and youth population and to the stresses and demands of modern society as they affect young people of all socio-economic backgrounds, as pointed out, particularly, in Chapter II. One important source of stress is that of poverty.

However, the precise extent to which poverty leads to higher rates of mental and emotional disturbance is unknown. This is a complex matter beyond the scope of this report—only a few main points will be given here. Although there appear to be higher rates of emotional and mental problems in the poverty population, it is not entirely clear whether poverty itself causes these higher rates or whether mentally ill people are more likely to drift into poverty. While this theory of drift would not apply to children, it might well apply to older youth and to the parents of children who present emotional and mental disorders. Moreover, fewer physical and mental health facilities that offer preventive services are available to the poor. Then, too, it appears that psychiatrists and other mental health professionals are more likely to diagnose members of the low-income population as seriously disturbed than might be the case if they were diagnosing people from other income groups (Schneiderman, 1965; McDermott, 1965; Hollingshead and Redlich, 1958). This is related not only to less understanding and acceptance of the poor but also to the fact that poverty evokes adaptive behaviors that might be labeled as emotional disturbance or mental illness in other, more affluent groups.

Thus, fatalism, distrust, physical aggression, and alienation from society are commonly found among highly disadvantaged people. These might be regarded as positive and helpful adaptations to the poverty situation. However, simply because these kinds of adjustments are called for because of the adversities of the poverty environment it does not mean that such adjustments are positive in the larger mental health sense. Rather, these behaviors indicate that the poverty situation, itself, must be corrected and that, for poor people, particularly, the community is also the patient.

Efforts to help disadvantaged children and youth make a more healthy adjustment to life will not be effective unless their life situation is also changed. On the other hand, this does not mean that mental health services should not be made available to the very poor. Rather, stresses in the environment should be relieved and, at the same time, high quality mental health services should be provided since changing the environment will not, by itself, cure all the problems that it has caused within individuals. (See, also, Chapter IV.)

Serious emotional and mental disorders are not limited to the poor, by any means. Being human is not easy for anyone. The processes of growing up are far from simple in our society. Probably all children and youth experience at least a few transitory emotional problems at some time in their growing up. These problems are related to the growth process itself and to the requirements that are placed on individuals if they are to become members of human society. The majority of our children, with the help of their parents and other social organizations, manage the strains of growth and socialization well enough so that, as adults, they function with a fair to excellent degree of adequacy, at least most of the time. (Chapters VII and VIII.) However, as we have seen, a large number of children and youth fail to escape the miseries and handicaps that are associated with serious emotional and mental disabilities.

CAUSES OF POOR MENTAL HEALTH

The causation of mental illness and severe emotional disorders is a complex topic. A full treatment of this subject is beyond the scope of this report; rather a few highlights will be given here. The causation of these disabilities is incompletely known and understood. There is general agreement among behavioral scientists and other mental health professionals that the causation of these problems is various and multiple and is related to the interaction of constitutional and biological factors; life experiences in growing up, especially in the family; and social and economic stresses and/or deficits in the larger environment. In the past decade, a shift in thinking has occurred within the mental health professions.

There is less focus on psychological conflicts within the individual and increasing attention is being paid to social, familial, and cultural factors. Then, too, over the past 30 years, psychoanalytic theories have placed increasing emphasis on developmental phases and crucial growth processes during infancy and childhood (Gioscia, *et al.*, 1968: Clinical Issues Committee, 1969).

Constitutional Factors

There is increasing evidence that constitutional factors present in the child at birth have considerable effect on his behavior and how he relates to people and things in his environment. These factors are related both to his genetic inheritance and to the physical health and situation of his mother during her pregnancy. For example, a child may be born with a hunger drive that cannot be satisfied owing to the physiological functioning of his body. Thus, he may develop a sense of distrust abd dissatisfaction in his environment and fail to form the necessary dependent and close relationship with his parents. The parents in turn may become increasingly frustrated with trying to meet the seemingly insatiable demands of this kind of a child.

Another example of constitutional factors and their effect on behavior is that of the hypersensitive child who finds pain, rather than pleasure, in being touched. He may, therefore, resist being cuddled and fondled by his parents. His turning away from them may eventually cause them to give up trying to make a relationship with him. This kind of situation is one of the factors that may be related in some cases to infantile autism or later neuroses.

Another situation is that of the hyper-active child who receives over-stimulation from his own body. This kind of child is extremely difficult to handle and he finds it hard to relate satisfactorily to his own environment. In an attempt to handle his own strong impulses, he may develop rigid controls over his feelings and activities and lose the important quality of flexibility of personality. Some children who are hyper-active suffer from brain damage; this situation, in and of itself, may lead to rigid behavior patterns. (It should be noted, however, that hyperactivity is not always associated with brain damage.)

Babies differ in activity level at birth. Some are always active and some tend to be quiet and passive; these tendencies will have differential effects on the reactions of their fathers and mothers depending on the kinds of behaviors valued by individual parents. Other constitutional differences can be seen in the way some babies readily adjust to regular routines and others continue to be unpredictable. Moreover, some babies adapt easily and adjust to changes in their life situation, whereas others object strenuously to any shifts. There are differences also in terms of sensitivity to stimulation, in ability to concentrate, and in length of attention span. It is important that parents understand the constitutional characteristics of individual babies and learn to be sensitive and adaptative to them. It is obvious that parents will differ in their abilities to make these kinds of adjustments. (See also, Chapter VII, Section I.)

It appears that a very small percentage of children are so biologically impaired at birth that even the most skilled and sensitive parents are unable to guide them into normal, healthy development.

Autism

A small number of children with very severe behavior and learning disorders are diagnosed as "autistic". These children usually display bizarre, extremely withdrawn behavior and have severe learning difficulties, although they are not mentally retarded. It is likely that autism is not one disorder but a group of disorders, the causes of which are complex and very incompletely understood. Some clinicians Battelheim for example, believe the difficulty to be psychological in origin, but another group of investigators believe that genetic or congenital factors are predominant. (See Chapter XII.) Parents of autistic children are faced with tremendous emotional and physical stress as they seek to care for and guide their handicapped youngsters. They must have help from the larger community in this respect so that they do not have to carry their heavy burdens alone. (See, also, Chapter XII, Research.) They also frequently need specialized mental health services for themselves and other family members because the presence of such a child in the family can play into complex difficulties in the whole family interaction system, including problems of family communication, depressive and guilt reactions of parents and siblings, etc.

Brain syndrome (often frequently also called "minimal brain dysfunction" or "brain damage") (Clements, 1966)

The concept of brain dysfunction as a primary causative factor in learning and behavioral disorders of children has received increasing attention over the past 20 years in the fields of medicine, psychology, education, and the language specialties. The rise in the number of so-called "children with minimal brain dysfunction" may, in part, be explained by one or more of the following factors: increased refinement in diagnostic techniques and skills over the last several years; b) the growing need for more exact classification of the learning and behavioral disorders of children; c) an apparent increase in the number of children with neurological impairments which, unfortunately, are often related to the improvement of medical services and the increasing ability of the medical profession to save the lives of babies with defects associated with genetic impairments or defects that develop during pregnancy or were related to injuries at birth; d) a growing dissatisfaction on the part of many professionals who deal with children who feel that psychological and social explanations of children's behavior problems and learning difficulties are not always satisfactory (Clements, 1966).

Brain syndrome disorders are thought to be caused by impairment of the brain tissue which may be brought about by a variety of factors including those already mentioned and: accidents, certain illnesses, disturbances in physical functioning, and seriously deficient nutrition. Although those disorders are relatively permanent, many children show a remarkable ability to compensate for them, to respond to special instruction, and to develop in a fairly normal fashion. The effect of these disorders is not necessarily always related to the severity and degree of brain damage. Outcomes in personality problems and learning disorders are related to the child's basic personality pattern, his current emotional conflicts, his level of development, the meaning of the disorder to the child and his parents, relationships within the family, and special services available in the community, most particularly in the school.

These disorders may not become particularly apparent until the child reaches school and may then show up in learning disabilities, such as difficulty in learning to read. Children with minimal brain damage often have normal or higher intelligence but may be labeled as being mentally retarded, primarily because their problems are incompletely understood and are inappropriately handled within the family and/or by the school.

Personality and learning problems associated with minimal brain damage are frequently difficult to diagnose partly because they do not present themselves in any particular pattern of personality or learning disorders. Diagnosis generally depends upon careful observation of the child and a detailed history of the many factors in his development (Group for the Advancement of Psychiatry, 1967).

Reactions to life situations

A disrupting crisis in the child's life may bring about a strong emotional reaction which can cause a variety of emotional disorders, one of the most common being a return to earlier levels of development. These crises may include severe illness or death in the family, an accident or serious illness suffered by the child, severe marital stress between the parents, father's loss of his job, and the like. Although the birth of a new baby could hardly be called a crisis, it may well be perceived as such by the child. How well a child adapts to such events as these depends on many factors: his own constitutional and psychological strengths, the reactions of family members, and supports and services available in the community.

Family behavior patterns

Although the experts vary in their points of view, there is growing recognition that a child's emotional disturbance is frequently, but not always, associated with the complex and intricate interpersonal relations within the family and the interactions that the family has with the larger social system. Some experts hold that difficulties within the family are not the basic *cause* of emotional disorders but family problems arise initially out of the larger social and economic scene as well as from the biological and behavioral characteristics of the child. "The structures, history, organization, boundaries, relationships of the family as well as the family's place in the larger social unit of the community are regarded as critical aspects of emotional disorders. Thus, these experts advise that there can be no complete diagnosis unless there is a family diagnosis (difficult and complex as that may be), and there can be no lasting cure unless the cure takes place within the natural environment of the youngster" (Task Force II, 1968; Gioscia, *et al.*, 1968).

However, there is far from complete agreement on these points. Some specialists take the view that emotional and mental disorders are very closely related in their causation to the attitudes, behavior situation and functioning of family members, especially parents. They call for an intensive treatment focus on intrapsychic conflicts within individual family members and between these members.

In reference to causation, there *is* clear evidence that lack of a close, dependable warm relationship between an infant and his mother or mother substitute is likely to have highly adverse effects on the physical and psychological development of the child. (See Chapter VII; Committee on Clinical Issues, 1969.) Also, as discussed in Chapter VII, children who are cruelly mistreated by their parents ("battered children") suffer serious personality, as well as physical, damage (Committee on Clinical Issues, 1969). Marital conflict between parents and family breakdown are also likely to have serious effects on the child's emotional health, as presented in detail in Chapter IV.

In actuality, it is extremely difficult to arrive at clear understandings of the various causative factors in emotional and mental disorders, partly because causes and effects are so intricately interwoven with each other and partly because such a wide variety of social, economic, psychological, biological, and situational factors are likely to constitute inter-connected roots of the problem. (See Chapter XII, Research.)

Cultural patterns

The cultural patterns or life styles of a family are largely derived from the social group to which it belongs. These patterns include values, goals, and attitudes that originally grow out of the group's responses to environmental conditions. These life styles are generally formed in early childhood and are deeply affected by the individual's experience within his own family, although each individual interprets these patterns in his own unique way. Such patterns have a strong effect on how children are reared and how the family conducts its life. These life styles are related to the family's national, religious, and ethnic background; even more strongly, in our society, they are related to the family's social and economic position in the community. Although, as pointed out in Chapter II, the cultural patterns generally found in each social class have their own particular deficits in reference to optimal patterns of child rearing, those life styles more frequently found among the very poor are particularly apt to be harmful to the mental health of the child. While it is recognized that these adverse patterns grow out of the grim necessity of adapting to a life of poverty, they interact with the many stresses imposed by poverty and tend to further undermine the growing child's opportunity for positive mental health.

Although research findings are, as yet, fragmentary and inconclusive they point to the seriousness of the problem. An overview of related studies strongly suggests that very poor people, to a greater extent than others, often fail to adopt child rearing and family life patterns that research indicates are associated with children judged to be mentally healthy. These findings are summarized in Table 7 below. (Those studies which reveal factors conducive to positive mental health include the following investigations; Glidewell, 1961; Roff, 1959; Baldwin, 1948; Antonosky, 1959; Block, Patterson, Block, and Jackson, 1958; Law, 1954; Peterson, Becker, Hellmer, Shoemaker, and Quay, 1959; Watson, 1957; Radke, 1946; Porter, 1955; Thompson, 1962; Baldwin, Kalhorn, and Breese, 1945. Studies related to the child rearing and family life patterns of the very poor include the following: Lewis, 1961; Myers and Roberts, 1959; McKinley, 1964; Handel and Rainwater, 1961; Davis and Havighurst, 1946; Rodman, H., 1959; Komarovsky, 1964; Herzog, 1963; Sewell and Haller, 1956, Bronfenbrenner, 1961; Clausen and Williams, 1963; Lewis, H., 1961; Miller and Riessman, 1961; Caldwell, 1964; Wortis, 1963).

TABLE 7

Child-rearing and family life patterns reported to be more characteristic of families of children who are emotionally healthy compared with relevant patterns reported to be more characteristic of very poor families.[1]

Emotionally Healthy Children	*Poverty Life Styles*
1. Respect for child as individual whose behavior is caused by a multiple of factors. Acceptance of own role in events that occur.	1. Misbehavior regarded as such in terms of concrete pragmatic outcomes; reasons for behavior not considered. Projection of blame on others.
2. Commitment to slow development of child from infancy to maturity; stresses and pressures of each stage accepted by parent because of perceived worth of ultimate goal of raising "happy," successful son or daughter.	2. Lack of goal commitment and of belief in long-range success; a main object for parent and child is to "keep out of trouble"; orientation toward fatalism, impulse gratification, and sense of of alienation.
3. Relative sense of competence in handling child's behavior.	3. Sense of powerlessness in handling children's behavior, as well as in other areas.
4. Discipline chiefly verbal, mild, reasonable, consistent, based on needs of child and family and of society; more emphasis on rewarding good behavior than on punishing bad behavior.	4. Discipline harsh, inconsistent, physical, makes use of ridicule; punishment based on whether child's behavior does or does not annoy parent.
5. Open, free, verbal communication between parent and child; control largely verbal.	5. Limited verbal communication; control largely physical.
6. Democratic rather than autocratic or laissez faire methods of rearing, with both parents in equalitarian but not necessarily interchangeable roles. Companionship between parents and children.	6. Authoritarian rearing methods; mother chief child-care agent; father, when in home mainly a punitive figure. Little support and acceptance of child as an individual.
7. Parents view selves as generally competent adults, and are generally satisfied with themselves and their situation.	7. Low parental self-esteem, sense of defeat.
8. Intimate, expressive, warm relationship between parent and child, allowing for gradually increasing independence. Sense of continuing parental responsibility.	8. Large families; more impulsive, narcissistic parent behavior. Orientation to "excitement." Abrupt, early yielding of independence.
9. Free verbal communication about sex, acceptance of child's sex needs, channeling of sex drive through "healthy" psychological defenses, acceptance of slow growth toward impulse control and sex satisfaction in marriage; sex education by both father and mother.	9. Repressive, punitive attitude about sex, sex questioning, and experimentation. Sex viewed as exploitative relationship.
10. Acceptance of child's drive for aggression but channeling it into socially approved outlets.	10. Alternating encouragement and restriction of aggression, primarily related to consequences of aggression for parents.
11. In favor of new experiences; flexible.	11. Distrust of new experiences. Constricted life, rigidity.
12. Happiness of parental marriage.	12. High rates of marital conflict and family breakdown.

[1] Source. Catherine S. Chilman, *Growing Up Poor*, U.S. Dept. of Health, Education, and Welfare, Wash., D.C.: U.S. Govt. Print. Office, 1966.

It should be noted that patterns of the kind listed on the right hand side of the above table are not limited to very poor families, alone, nor are they found universally among the very poor. Moreover, these patterns should not be considered to be an indictment of low-income parents but rather of the poverty situation and the social structure which tends to produce life styles that are related to fundamental psychological depression, poor impulse control, hostility, and/or surrender to overwhelming odds.

Social and economic stress

Continuing pressures imposed by the environment are seen as one set of factors that may play an important part in causing serious mental and emotional disorders. Individuals have varying ability to withstand environmental pressures; this ability relates to their physical constitution, their previous life experiences, their present situation, and their anticipations and attitudes towards the future. Some children and young people are able to withstand very considerable stress while other have more limited strengths to cope with it. The severity and duration of stress also must be taken into consideration in terms of its effects. Along with those stresses imposed by the many pressures of a life in poverty are other pressures felt throughout most of our society. They include the explosive force of today's social and economic changes, life in the city, the terrifying threat of the nuclear age, conflicts between the races, air and water pollution, the population explosion, and the like. (See, also, Chapters II and III.) Individuals also experience their own particular stresses such as conronic illness or physical handicaps, continuing financial pressures, frequent moving, difficult employment situations, and so on.

PRESENT MENTAL HEALTH PROGRAMS

There is a critically severe shortage of mental health services of all kinds in this country as we remarked at the beginning of this chapter. This situation is especially severe in reference to the needs of children and young people. This shortage exists in relation to diagnostic, treatment, consultative and special education services. The services that do exist tend to be overcrowded, under-staffed, and poorly coordinated with other mental health and mental health-related programs. We need not only a far greater number of mental health services but we need a reorganization of the whole mental health system. Coordinated services are required for children and families and these services should be linked to the developmental stages of the child's life.

Current programs aimed at the needs of children have the following similar characteristics:

1. large areas of unmet need and a mismatch between the population that is currently being served and the population that is most in need of such services,
2. an informal underground system that people use to get what they need (such as, for example, a resort to faith healers, "magic cures," and the like); this indicates that the current programs are either not suited to the needs of people or they are not extensive enough,
3. a multiplicity of federal, state, and local public and private services which overlap with each other and which fail to meet all areas of need,
4. a lack of clear, relevant data as to the extent of mental health problems, the extent of mental health services, the effectiveness of these services, and the relation of these services to other unmet needs of children and youth. The data that do exist are usually specific to particular operating programs (such as the number of patients in mental hospitals) and are not related to the needs of people at different points in the developmental cycle (Task Force V, 1968).

In order to diagnose and treat emotional disturbance and mental illness in children, a coordinated network of services is needed that includes the following elements: diagnostic, consultative, and treatment services available in outpatient clinics, residential centers, half-way houses, day and day-night services, emergency services, and supportive programs, including special programs in regular schools, and mental health consultation to parents and teachers (see, also, Chapter IX, Education). No community has all of these services available for all who are in need of them; few communities have such programs even for a portion of the population; some communities have virtually no mental health programs. In those few communities where most of these services are available, the programs are apt to be fragmented and lacking in provision for continuity of care for children and youth in different stages of their growth. Thus, the majority of young people who are in need get no services; a large group get only diagnostic, but no treatment assistance; in general, only a few—mostly the very rich—get all they need in a coordinated way, mostly through their access to private facilities and the care provided by private psychiatrists.

The very poor are most in need of mental health programs but they are least likely to have access to them. There are many reasons for this tragic state of affairs. For example, mentally ill and emotionally disturbed low-income children and youth are often seen as being untreatable by psychiatrists (Hollingshead and Redlich, 1958; Rudolph and Cumming, 1962; Gordon, 1965; Schneiderman, 1965). A number of studies show that the kind of treatment that is provided to individuals is strongly related to their social class. This is also true in relation to the length of treatment provided and the kind of diagnosis that is given to the person's illness.

Lower-class people are less likely to be given intensive psychiatric treatment, are more likely to be treated by inexperienced therapists, and are more apt to be labeled as psychotic or near-psychotic (Schneiderman, 1965; McDermott, 1965; Dunham, 1964; Hollingshead and Redlich, 1958). It has also been found that lower-class individuals have far higher drop-out rates from treatment than do middle-class and upper-class persons (Baum, 1966; Cole, 1962, Rosenthal and Frank, 1958).

According to NIMH reports, about 473,000 children under 18 years of age received some service in a psychiatric facility in the United States in 1966. Of these children, 84 percent were seen on an out-patient basis and 14 percent were hospitalized. As shown in the Table below, children made up about one-third of the total case load of out-patient psychiatric clinics. In contrast, three to eight percent of the case loads of inpatient facilities was made up of persons under 18 years of age.

TABLE 8.—NUMBER OF PSYCHIATRIC FACILITIES AND ESTIMATED NUMBER OF CHILDREN UNDER 18 YEARS OF AGE UNDER CARE DURING THE YEAR IN EACH TYPE OF FACILITY, 1966[1]

Type of facility	Facilities		Total patients—all ages		Children under 18 years of age		
	Number	Percent distribution	Estimated number	Percent distribution	Estimated number	Percent distribution	Percent of total patients in each type of facility
Outpatient psychiatric clinics[2]	2,122	56	1,186,000	46	399,000	84	34
State and county mental hospitals	297	8	807,000	31	27,400	6	3
Private mental hospitals	175	5	105,000	4	8,400	2	8
General hospitals with psychiatric services	888	23	466,000	18	28,000	6	6
Psychiatric day-night units[3]	173	5	15,600	1	2,500	1	16
Residential treatment centers (not in State mental hospitals)[4]	149	4			8,000	2	
Total	3,804	100	2,579,600	100	473,300	100	18

[1] Source: "Utilization of Psychiatric Facilities by Children, NIMH, Mental Health Statistics, series B, No. 1, (U.S. Govt. Print. Off.) 1968.

[2] Includes clinics of the Veterans' Administration.

[3] Based on survey conducted in 1965 providing estimated number of children served in 1964. Includes day-night units of the Veterans' Administration.

[4] Based on the average capacity or average number of residents reported for 92 facilities. Source: Directory of Facilities for Mentally Ill Children in the United States, 1967, The National Association for Mental Health, Inc.: The Directory for Exceptional Children, F. Porter Sargent, 5th edition, 1965.

The number of children under 18 years of age receiving care in psychiatric clinics has almost doubled since 1959. This growth in the patient case load is only partly due to the increase in the child population in the United States. It is also related to the greater demand for and availability of these services. The number of patients under care during this period increased more rapidly than either the number of clinics of the professional man-hours available.

The adolescent group, aged 10 to 17 years, made up two-thirds of the children served and, in fact, for boys was the largest group of patients of any other age span. Children, age five to nine years, accounted for another third of the patients under age 18. Pre-schoolers accounted for only six percent of the clinic child population. Twice as many boys as girls were given service in clinics. At age 18 or 19 years of age, the rates for boys dropped sharply and this drop is closely related to the lack of major community programs (besides the school) which may serve as case finding and referral agencies for young adults.

Thirty-four percent of the children who were terminated from clinic service received a diagnosis of personality disorder related to their life situation. A large proportion of children received no diagnosis and this reflects, to a large extent, the brief contact that many children have with the clinic. Diagnosis of brain syndromes and mental deficiency accounted for almost half of the very young children under age five.

The huge majority of children in state or county mental hospitals were over the age of 10 and over half of them were between ages 15 and 17. Again, boys out-number girls two to one for first admissions to these hospitals. Once they are hospitalized, they also tend to remain longer in the institution. The major diagnosis for these hospitalized young people was schizophrenia and personality disorders.

As shown in Table 8, over 27,000 children under age 18 were in state and county mental hospitals in 1966. In most of these hospitals, the usual practice is to place youngsters in wards with adult patients; frequently with patients who are in an advanced stage of mental deterioration. They receive little, if any, therapeutic care and no provision is made for the continuation of their education. An imprecisely determined number are left to "rot on the back wards," condemned to a hopeless life of continuing institutionalization. Another large group of young people, whose chief problems are those of emotional disturbance or mental illness, are institutionalized as being delinquent or mentally retarded and receive no treatment for their disabilities.

The Commission takes the position that no child or young person should be placed in a mental hospital without a careful professional diagnosis of his condition and preliminary attempts to help him through other forms of treatment on an out-patient basis in his own home or, at least, in his home community. If he must be hospitalized, care should be provided in a special treatment unit for children or adolescents, as the case may be. Provision must be made for continuing therapy and attention to his educational and recreational needs.

Very little data are available on the number and characteristics of patients served in private psychiatric practice. One study showed that about four percent of private psychiatric patients are under age 15. It thus appears that relatively few children receive private psychiatric care. As of 1967 the Community Mental Health Centers, which are relatively new, were serving only 1,400 children under age 18—about 20 percent of the total patient case load. Two-thirds of the children served in these centers were boys; of those children under age 12 boys outnumbered girls three to one (NIMH, 1968). In a recent paper, Tarjan dramatically presents the dearth of mental health services available for children and youth in the average community (Tarjan, 1969). In reference to an imaginary, but average, community Tarjan presents the following picture: "The child population under 18 in the city is approximately 300,000. About 50,000 individuals, including 18,000 children qualify as "poor" under the customary standards; most of these people live in one sizeable ghetto. Among the 110,000 children there are some 7,500 who are emotionally disturbed, including 750 who are overtly or severely sick.

"Approximately 20 children between the ages of five to 15 are diagnosed as autistic or schizophrenia. Three thousand children are diagnosed as mentally retarded with 500 falling into the moderately to more severely impaired categories. Almost no information is available on the prevalence of mental illness in the poverty population. It is very probable, however, that for most mental disorders the rates are higher than those found in the middle or upper socioeconomic classes. Even cursory review suggests, for example, that mild mental retardation as diagnosed by the school system, occurs 15 times as often in the city's minority population than in the residents of the suburbia-like areas.

"All types of treatment resources are in short supply, even those that, to some measure, might substitute for psychiatric care. The city is served by a state mental hospital which cares for a population nearly three times as large as that of the city. The state hospital has no special programs for children, even though from the city alone nine children under 15 are in residence and a minimum of six are admitted yearly. There is neither a private psychiatric facility with a specialized program for children nor is there such a program in the two general hospitals which have a few psychiatric beds.

"There are three psychiatric clinics but only one serves children, the others take only an occasional child for diagnosis. The three clinics see some 400 children under 18 per year. This may sound like a large number but it must be compared with the size of the emotionally disturbed child population of 7,500. We must also realize that only 100 of the 400 receive any treatment, others are seen, at best, for diagnosis. The clinic that gives some preference to children operates with a series of waiting lists: one for intake, one for diagnosis, and a hopelessly long one for treatment.

"A Community Mental Health Center is about to open in temporary quarters. The people expect that the Center will pick up much of the slack in services for children, but the fact is that it will be overwhelmed by the needs of adults and therefore will postpone caring for children. A community facility for the mentally retarded is also under construction but it will be geographically located to serve the moderately to more severely retarded children of the middle classes and, for all practical purposes, will be unavailable to the citizens of the inner city where diagnosed mild retardation is most prevalent. It is also of importance to note that no special classes for emotionally disturbed children exist in the public school system and that the special program for the retarded reaches only two-thirds of the eligible educable and one-third of the trainable children.

"It is obvious that the city cannot serve as a model for the delivery of community services and treatment. Yet, like most communities, it has one program relevant to childhood mental health which fills the city with pride. It is a private day school which cares for a few psychotic, severely emotionally disturbed, and neurologically handicapped children.

"There is only one certified child psychiatrist in this city; he devotes most of his time to private practice and contributes only a few hours to one of the clinics. One child psychiatrist for 110,000 is near the national average. However, it would not be illogical to set a goal of one child psychiatrist for 15,000 children because in such a group one finds 1,000 who are emotionally disturbed, with 100 overtly sick. Parenthetically, we may note that there are some 20 general psychiatrists in the city but very few with interests in child psychiatry. The manpower situation is no better in such important fields as psychology, social work, or psychiatric nursing."

Care for emotionally disturbed and mentally ill children outside of their own homes

Intensive individual or group care outside the child's own home may be required for youngsters with severe emotional disorders and mental illness. The severity of their disorders presents extremely complex problems: those of deep emotional hunger, extreme over-activity, withdrawal from the outer world, extremely high levels of aggression, violent uncontrolled behavior, bizarre and incomprehensible reaction patterns, and the like. These children require the help of highly trained mental health specialists who work as directors and consultants to a team of other professionals and non-professionals who are needed to provide the wide range of services that are essential for the full care of such children. These children need more than individual treatment; they need an all-embracing care which is therapeutic in nature and which includes attention to their total development. For instance, they need individualized, highly skilled attention to their educational and recreational needs; their daily routine needs to be handled with psychological skill; usually, counseling services should be made available to their parents.

Other important features of such care include the provision of an environment which is therapeutic in all of its aspects and the ready availability of trained personnel to conduct "life-space interviews"—discussions with children of their difficulties at the moment they occur or at the moment the child feels ready to talk about them.

When the child returns to his own home—often after a rather long period of treatment—he should be followed up with therapeutic services that extend to other important people in his environment such as his parents and his teachers. Because children have such a wide range of needs and because intensive treatment is necessary for very sick youngsters, the costs of such care are apt to be high. For instance, the costs of residential treatment centers are generally estimated at between $10,000 and $18,000 a year. It is argued that effective residential treatment at an early age may well save later costs which may be much higher in terms of the burdens that untreated, ill children are likely to impose upon themselves and on society.

At present, the numbers of residential treatment centers in this country are extremely small and such treatment is not available to the huge majority of children who are in need. The costs of such centers are so high that it appears that they cannot be extended and adequately financed unless federal aid is made available for this purpose (Clinical Issues Committee Report, 1968).

For the lack of enough residential treatment and other specialized facilities, seriously disturbed children or children whose families cannot care for them, but who need expert help, are placed in a number of inappropriate settings where their problems are likely to become more, rather than less, severe. These settings include mental hospitals which are designed for adults; institutions for the delinquent or the mentally retarded, or foster homes which are not well prepared to care for ill or disturbed children. Many ill, neglected children receive no treatment at all but rather, roam the streets and the countryside where they are a potential danger either to themselves or others. Emotionally disturbed or mentally ill children from low-income and/or minority group families are particularly likely to be misdiagnosed and placed inappropriately in such facilities or neglected altogether.

In 1968, a survey revealed that 97 percent of the children in residential treatment are in private institutions. In 1966, there were a little over 8,000 children in residential treatment centers although it is estimated that there are over 1,000,000 mentally ill youngsters in this country. While not all of these children may need residential care, it is still clear that a great many who do need it are not receiving such care.

There were 276 residential treatment institutions for emotionally disturbed children in this country in 1966. A number of states had no such institutions. These included: Alabama, Arkansas, Georgia, Hawaii, Idaho, Mississippi, Nevada, Puerto Rico, South Carolina, Utah, and the Virgin Islands. The states with the largest number of such institutions are: California (38), Illinois (12), Massachusetts (27), Michigan (17), New York (24), and Wisconsin (14). A number of states, primarily those in the far west and in the southeast, have only one such institution (Papenfort, *et al.*, 1968).

Some of the existing residential centers have weaknesses or deficits in their programs. This is apt to be particularly true of a number of institutions which offer care for emotionally disturbed or mentally ill children but which do not come up to the standards set by such professional organizations as the American Association for Children's Residential Centers. Conspicuous inadequacies, in some of these institutions, as described by some specialists in the field, include the following:

In some institutional programs, well-trained staff members work with the children eight hours a day, five days a week, with the children cared for in the evenings and on weekends by personnel with the least training. Communication among the many professionals is often inadequate.

Many institutions for disturbed and retarded children provide diagnostic services only, with no place for children and their families to go to get help.

School is neglected or given secondary emphasis in many if not most residential treatment programs. Teachers are far down in the prestige hierarchy. They are often provided by public schools, are seldom the best teachers, and frequently remain on the fringe of the professional staff, and seldom are central to it.

Very few institutional programs have adequately conceptualized and staffed liaison programs to work with the child's family, school, and community, to speed his return and to follow-up to promote continuing progress and adjustment.

Once children are admitted to institutional programs they tend to remain for long periods of time, which may often be more a matter of custom than of the child's condition. A lengthy institutional stay is often associated with an inadequate liaison service.

Fully staffed residential treatment programs involving the traditional psychiatric team (psychiatrist, clinical psychologist, psychiatric social worker, psychiatric nurse, sundry kinds of therapists, teachers, aides) are expensive, as already indicated. Moreover, highly trained personnel required for such programs are now and will remain in short supply. These facts mean that we cannot meet requirements for residential care for all children needing it by building exclusively on the psychiatric team model. Such programs are essential but must be used selectively, with clear goals in mind and costs carefully considered.

Few residential treatment programs evaluate the outcome of their work in rigorously designed, well-controlled, scientifically objective studies.

These are harsh criticisms but progress is not likely to be made until we take a hard look at current practice. This is not an indictment of any state or professional group. There are good residential treatment centers throughout the country, under varied auspices, inspired by psychiatrists, teachers, social workers, psychologists, at varying levels of cost. And there are many bad institutions that are underfinanced, under-staffed, and poorly housed, whose devoted and overworked professional staffs know better than anyone how inadequate the places are and how much needs to be done. On the whole, we are doing a very poor job in supplying residential care for disturbed children.

There are times when a problem cannot be solved following accepted assumptions and procedures; such seems to be the case now in our efforts to extend traditional treatment models for the residential care of all emotionally disturbed and mentall ill children who need intensive specialized treatment. A not-too-sharp pencil can show what the problem is. Assume a most conservative estimate of the number of seriously disturbed children, say one-half of one percent of children under 20. That means 450,000 seriously disturbed children in need of treatment. Assume that a psychiatric team is composed of one psychiatrist, one psychologist, two social workers, and three nurses—not to mention teachers, aides, etc. Give them a treatment load of 50 children in residence or intensive day care, a much heavier load than they can handle. This arrangement would require 9,000 child psychiatrists (more than one-half the psychiatrists in the country), 9,000 psychologists (more than the entire number of clinical psychologists), 18,000 social workers, and 27,000 psychiatric nurses. Assume further a per-day treatment cost of $40 which is on the low side. The annual cost of the program would be

$6,570,000,000. Since traditional treatment programs tend to require about two years, this amount would need to be doubled to care for the children now estimated as being in need of help. Double the case load to reduce personnel requirements and the resulting figures are still staggering. The problem of residential and intensive day care for severely disturbed children simply cannot be solved the way we are trying to solve it.

Therefore, it is important to experiment with other approaches to care for disturbed children who, for one reason or another, cannot remain in their own homes. These approaches include other kinds of group care, such as those pioneered by Project Re-ed (see last section of this Chapter), day care or night care programs, use of specialized foster homes, therapeutic nursery schools, and the like. In these programs, very careful consideration should be given to expert diagnosis of the nature of the child's problems. Differentiation should be made between those youngsters with such severe disorders that highly intensive psychiatric and other forms of medical care are essential and those children who are likely to respond well to a more generalized approach. These various forms of treatment and care should be tried on an experimental basis and carefully evaluated with well-designed program research. (See Chapter XII.)

Included in such experimental approaches should be a more flexible use of mental health specialists who serve as consultants to other professionals, such as teachers and nurses, who are working directly with seriously disturbed children. Then, too, expanded use should be made of para-professionals: people without formal training in the field but who may do an excellent job in some aspects of group care for disturbed children, providing that such personnel receive appropriate in-service training, consultation, and supervision (Chapters XI, XII). (See, also, section in this Chapter on services for adolescents and specialized programs in state hospitals.)

Mental health services for children, in general

In reference to the provision of mental health services for children, in general, a number of problems are apparent. In discussing those related to very young children, the Clinical Issues Committee Report (1968) identifies three major difficulties, as follows:

1. There has been a tendency for many years to regard pre-schoolers as the primary psychological property of their parents; thus, treatment has been aimed at the parents, although clinical experience indicates that the child himself also often needs treatment before his problems become too rigidly imbedded in his personality.

2. There is a widespread lack of training and special professional skill developed for dealing with pre-school children. The average child psychiatrist does not have specialized preparation for working with younsters of this age.

3. There is a strongly held belief that pre-school children should never be removed from their own homes, However, recent studies are indicating that children of this age may benefit from care in specialized foster homes, day care centers, or residential centers if there are assurances that the child will receive a high quality of continuous care from parent substitutes.

While changes in the child's environment and the provision of supporting services such as day care and counselling to his parents may be extremely useful for many children, some youngsters need direct individualized psychotherapeutic help (Neubauer, 1967).

Services for adolescents

Much of the treatment of the troubled teenager has fallen to clinics and private practitioners, but the major unmet need in this area is that of vastly improved institutional care. An enormous number of teenagers pass into and out of state institutions each year and instead of being helped, the vast majority are the worse for the experience. This is true for the average state training school or state industrial or state farm for boys or girls; it is true, also, of the state hospital in many areas.

The admission of teenagers to the state hospitals has risen something like 150 percent in the last 10 years. The number of youngsters in correctional institutions is also increasing. And few if any of these situations provide anything approaching adequate treatment or rehabilitation.

The usual picture is one of untrained people working without facilities attempting to deal with a wide variety of complex and seriously sick youngsters and and producing results that are most easily measured by a recommitment rate that is often 30 to 50 percent and occasionally higher.

The need for intensive skilled clinical and educational work with these many troubled youngsters and their parents is crying and urgent and it is imperative that public attention be turned toward this shameful and correctible condition. State hospital programs for teenagers are still seldom geared to the special needs of the adolescent population. Many youngsters are placed on adult wards, usually to their serious detriment, without benefits of the special recreation activities, education, supervision, and group experiences that teenagers need. The result is at best a partial treatment program with many gaps left in what could be a major assist toward recovering from their illnesses.

Although this is the most glaring lack in programs for teenagers, mental health facilities in general are seriously lacking for this age group. Many child guidance clinics take youngsters only up to age 11 or 14. For the older adolescent, even the relatively commonplace clinic service is lacking and out-patient care is only one of a whole series of necessary services. For example, the nature of adolescence is such that to meet the needs of this period of life there must be a facility that will offer emergency service for the upset teenager at any time. Backing this up there must be a whole array of services beginning with a group living half-way house.

This might be a professionally run youth hostel, with provisions for long-time residents who would live there for an extended period in a protected and supervised state until they were ready for full community adjustment. At the same time, such a hostel would include facilities for transients, for youngsters under pressure who would leave home for a night or two or a week or two if they felt they must. It could provide a haven under socially approved auspices where they could also look for relief from home pressures and outside help.

Protected work situations are necessary for many youngsters where remedial education and on-the-job training can give them a sense of career and direction. For the more disturbed boys and girls, a day care set-up is recommended where work-training, school, recreational activities, therapy, group work, and in short, a total treatment program are all provided under one roof. To put it briefly, insofar as mental health care is concerned, as a society we fail our teenagers at almost every level (Clinical Issues Committee Report, 1968).

RECOMMENDED MENTAL HEALTH PROGRAMS [1]

Programs attuned to development stages

Mental health programs should start before pregnancy with provisions for genetic counseling and family planning services. With increasing information becoming available regarding some of the genetic factors that are related to mental retardation and physical handicaps, it is important that parents have access to skilled, sensitive counseling on this subject. Family planning should be available to all parents or prospective parents regardless of age or marital status, since an unwanted pregnancy presents a threat to the mental health of both the mother and her unborn child. Moreover, abortion services should be available at the request of the mother for the same reason.

As emphasized earlier in this chapter and in Chapter VII, much more emphasis should be placed on providing a wide range of mental health and related services to expectant mothers and infants and their parents. Current research into early learning in infant life suggests that the kind of learning that goes on in the early months and years is probably more significant than anything that the child is going to learn during the rest of his life. The evidence is fairly weighty that if severe deficits occur in early infant experiences, later therapy is likely to have only a partial effect. We do not yet know to what extent early deprivations can be undone later by therapy. Critical points in human life such as pregnancy, child birth, infancy, toddlerhood, pre-school and school entry can present opportunities to work with families and help parents rear their children more appropriately, This approach to families with very young children requires a large commitment on the part of the whole society to seriously regard the human development of infants and children as a very serious business (Gioscia, *et al.*, 1968).

In general, services to children or affecting children must be organized along the lines of the child's developmental stages and his needs at these different stages—this will be also true for the training of specialized personnel to deal with the characteristic problems of each period. It also applies to the nature of agencies, . . . their types and locations . . . and to the practices and community relations of each individual involved with children. The range of childhood includes the prenatal care of the pregnant mother on one end of the spectrum and the transition of the college-age youth into young adulthood at the other.

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[1] In reference to most of the recommendations that follow, there is a lack of firm, research-based evidence as to the effectiveness of the various kinds of programs that are recommended. However, the need is so acute that it is not possible to delay action until all the needed research is completed. Basic and applied research must take place concomitantly with the launching and operation of a wide range of services. (See Chapter XII.)

A wide range of coordinated preventive and treatment services

Establishment of services and training programs should include these goals: the treatment of every child as well as the family around the child wherever demonstrable emotional and mental disorders are found; an attempt to prevent these disorders by large-scale planning; and the reorganization of services in a way that will encourage the maximum flowering of each person's individual potential for self-realization and social contribution. In this planning, it is imperative that services be individualized and adapted to the needs of specific individuals (Clinical Issues Committee Report, 1968).

A broad range of coordinated remedial mental health services must be provided for the seriously disturbed, juvenile delinquent, mentally retarded, and otherwise handicapped children and their families. It is strongly urged that future services to the child be given according to the child's level of functioning rather than on the basis of diagnostic labeling. This will mean that children with many different diagnostic labels will be treated jointly under the same service program. Further, it is recommended that community-based facilities be developed so that children and youth can be kept as closely as possible within their normal, routine setting. For the more severe cases who must be removed from the normal setting, it is recommended that there be further development of residential treatment centers, special units in general and psychiatric hospitals, and separate care-taking provisions for children and adolescents in state hospitals.

Plans for care of the emotionally disturbed or mentally ill child should be based on: a) the behavior stability of the child, b) the strength and capacity of the family to support him, c) the resources of the community. The disturbed child is likely to need a wide variety of services and it is essential that arrangements be made so that he may move easily from one service to another. Many emotionally and mentally disturbed children are excluded from services that they need either because a general service has made no provision for such children or because the cost of specialized services for these youngsters is beyond the means of the families involved.

The following are the services that are necessary for a comprehensive mental health program for troubled youngsters: 1. information referral services easily accessible and equipped to direct families to available services, resources, and facilities; 2. comprehensive developmental and psycho-educational assessment of each child's special treatment and educational needs should be made as early as possible by a team that may include a pediatrician, psychiatrist, social worker, neurologist, psychologist, speech and language specialist, ophthalmologist, audiologist, educational specialist, and/or any other professional disciplines available and considered essential for the proper treatment of the disturbed child. Highest priority should be given to the coordination of these services so that a comprehensive diagnosis is possible.

This assessment service should assume responsibility for following up recommendations and referrals and for on-going, periodic re-evaluations to make certain that the appropriate and adequate community treatment, training, and educational facilities are available.

3. Treatment for the child and his family when indicated. Psychiatric, psychological, social work, educational and other support services should be available as needed.

4. Special education programs must be an integral part of the range of services to be provided:

a. Pre-school home training program should be established for the special training and education of disturbed children and for the guidance and counseling of their parents.

b. Regular nursery schools can help children who show inadequacies of learning and adjustment skills. There are, however, children who are too disturbed or disruptive to be contained in a regular nursery school. These children should have special nursery schools offering a variety of techniques and approaches to correct or reduce maladaptive behavior. Special classes within regular schools offer advantages for those children who need a somewhat more intensive program. These classes are usually close to the child's home and can be partially integrated with regular classes.

c. Special schools should be established under public school auspices or by voluntary agencies with government and public support for children who, because of the severity of their disturbances, cannot be accommodated in special classes within a regular school.

5. Rehabilitation is needed to provide a plan and purposeful process of restoration, remediation, and psycho-social adjustment.

6. Residential care which may be provided by specialized foster homes, group residences, residential treatment centers, sheltered villages, or hospital settings. It is essential that these facilities offer comprehensive treatment and have adequate resources for medical care, psychological and psychiatric consultation, special education, and other support services.

7. Transitional services must provide the resources to meet the inability of the family to care appropriately for the child, the inability of the school to provide adjusted educational services, the infrequent availability in the community of intensive out-patient treatment or other services for the child and his family or or some combination of these. Transitional services may include partial hospital care as in day or night hospitals; half-way houses and hostels; and social habilitation programs. In offering transitional services to children and adolescents it is necessary to recognize that hospitalization is usually deemed necessary when the child's disturbed behavior is acute and over-taxes the supports offered either in the home or in the community, especially the school. The child's inability to assume independence of functioning is often the chief block to early release from hospital care. This highlights the need generally for more adequate community-based services and most particularly the need for transitional services. Every effort should be made to not place children in hospitals except during the acute stages of physical and/or emotional illnesses when intensive medical care is needed.

8. Relief services for the families of severely disturbed children should be provided. In any plan to provide partial hospitalization and transitional services, the goal should be to use supportive services to keep the family intact. Examples of the above services are foster grandparents, baby sitting, homemaking services, day care, public health nursing, and home-bound services.

9. Within the systems of services there should be periodic assessment, evaluation, and follow-up to ascertain that the child is receiving maximum benefits from the system (National Association for Mental Health, 1968).

Comprehensive continuous programs such as those outlined above might well be tied in with the functions and activities of the Child Development Councils recommended by this Commission and carried out in relation to community mental health programs.

Further recommendations are available from the American Association of Psychiatric Clinics for children. They are as follows: 1) services which reach larger numbers of children at earlier ages or at earlier stages of disturbances are generally less expensive, more short-term, and achieve a more favorable effect than those services which reach children later on when the children are more deeply disturbed; 2) the soundest progress in community organization for emotionally disturbed children and their families is achieved by developing services in "developmental succession"; Preventive before diagnostic, diagnostic before outpatient treatment, out-patient treatment before hospital care, and so forth; 3) communities with inadequate educational, preventive, diagnostic, and treatment resources are compelled to move children out of the community into institutions instead of reaching younger or less disturbed children more quickly and treating them with shorter, less expensive community and out-patient services. 4) In practice, it may be soundest to begin by making better use or refocused use of existing services than to establish and promote new services immediately. If a small community, for example, has a family service agency but no out-patient clinic, the addition of psychiatric services to the agency may be more economical than establishing a clinic itself.

5. No program can be soundly based which does not include careful diagnostic evaluation as a basis for any service or treatment planning. Such diagnostic evaluation means evaluation not only of the child and his problems but of the parent-child relationship, the parents, and the relationship of the family unit to the community and its resources. 6) When more specialized services are required, the transition for the child and his family should be as simple and direct as good community organization and intra-agency cooperation can make it. 7) The multiple roles of the psychiatric clinicians and psychiatric services today have come not only from the many demands of various community services but have also come from the contributious made by the many new directions in the filed of medicine. For example, the contributions of psychopharmacology and genetics are having special present significance. Psychiatry is involved in the general present movement of medicine toward health preservation and the prevention of illness. 8) The child psychiatric clinician and the child psychiatric services today need to be aware of important class differences, ethnic differences, value

differences, differences in belief regarding the role of the individual and the relationship between individual and group needs. Many different professional groups using many different resources have both an opportunity and an obligation to participate in helping troubled children and their families. However, it is precisely because the problems of an emotionally disturbed child are determined by many factors that the child psychiatric clinician and the child psychiatric services are useful in deciding which factor to be corrected is critical and assessible to change. The unique contribution of the staff member of the child psychiatric service is his specialized clinical insight and his application of this to the methods of helping children.

Some mental health experts warn, however, that we should recognize that there is an extreme shortage of child psychiatrists in the country, not nearly enough to serve the function described above. Obviously, we must perfect new patterns of care that will use new kinds of personnel and extend the range of effectiveness of the child psychiatrist. (See, also, Chapter XI.)

Community planning for mental health

When a community plans for psychiatric services for its children, it must be concerned with the quantity and quality of the health, educational, recreational, and welfare services which it provides for all its citizens. Services for emotionally ill children and their parents cannot be set up in a vacuum. They are related to, and affected by, other programs and services: both those concerned with children and those concerned with adults. All community services overlap and complement each other. They should be thought of as parts of a whole, not separate and unrelated programs.

Planning for comprehensive mental health programs should be coordinated with planning now going on in such areas as urban renewal and public housing, juvenile delinquency, the poverty program, and mental retardation. It should be stressed as strongly as possible that mental health services for children are one segment of the total services in a comprehensive mental health program and that many and diverse facilities are component parts of this segment (American Psychiatric Association, 1964).

In planning such programs, states within a regional area, particularly those that are sparsely populated and have few facilities, may well coordinate the development of their programs on a regional basis.

In developing programs, certain fundamental principles of planning may be set forth: 1) emotionally disturbed children can be helped more effectively or adequately in communities that have a wide-range of educational, preventive, diagnostic, and treatment facilities than in communities where there are a narrower range or with a marked lack of such facilities; 2) services which reach children at early ages and at early stages of emotional disturbance are generally more effective and therefore there should be a focus on treatment of young children and on early detection and treatment of emotional illness; 3) continuity of treatment for the individual child and his family should be a major consideration in organizing a program; 4) the order in which various facilities are initiated varies from one community to another. This depends basically on the services available, the degree of coordination among them, and attitudes in the community (American Psychiatric Association, 1964).

Particular attention should be paid to the needs of low-income children and their families whose problems are likely to be particularly diverse and acute and who are likely to especially lack needed services. In the past, the emotionally disturbed children from this group have tended to reach mental health clinics chiefly through referrals from juvenile courts and welfare agencies. Effective work with these children and their parents calls for a multiple approach and active cooperation with schools, juvenile courts, welfare agencies, child care centers, public health nurses, neighborhood recreation workers, and the like.

Imaginative new methods may well be necessary for reaching and holding such families who tend to distrust middle-class professionals and the middle-class patterns of mental health services. These techniques include involving young people and parents in the planning and staffing of mental health facilities, using community outreach workers, involvement of parents and youth in neighborhood projects, and reaching parents through their participation in such programs as Head Start. At the same time, attention must be paid to the many adverse aspects of the poverty environment itself and the multiple reality problems that weigh so heavily on poor people such as poor housing, lack of income, lack of community services, unemployment, rejection and discrimination, and the like. Moreover, the cultural patterns of the very poor must be deeply understood and respected, both in terms of their cause and their effect on behavior.

In order to assure continuity of care for all children and young people, organizational arrangements should provide the following: 1) ready transfer of relevant information about patients from one facility to another, with the permission of the parents and with adequate protection of confidentiality so that information can be used to the best advantage and duplication of history taking and services can be minimized or avoided;

2) sustained use of the same treatment personnel in different facilities to the maximum extent possible to avoid the disruptive effect of shunting the child from one stranger to another. For example, if a child who has begun treatment in an out-patient is seen later to have a more serious problem or if a family crisis intensifies the child's disturbance, hospitalization may become necessary. When the geographical location of a state or other hospital makes it possible, arrangements may be made, through cooperative planning, for the child's original therapist to continue in this role throughout hospitalization and during after-care. 3) An unrestricted policy for the admission and transfer of children and families to various facilities through some arrangement for cooperatively determined clinical need. This unrestricted policy should be maintained without regard to ability to pay and with no residential requirements other than those imposed by whatever regionalization plan is in operation.

The mental health professional performs a wide range of functions. One of them is in his role as consultant. As a specialist, he uses his basic diagnostic and treatment skills in the important function of consultation with medical specialists, general physicians, non-medical child care personnel, and teachers. He works as a member of the diagnostic and treatment team. This team may include psychiatrists, pediatricians and other physicians, clinical psychologists, social workers, public health nurses, guidance counselors, teachers, speech therapists, neurologists, occupational therapists, and the like. He also has a role as consultant to the community in terms of community planning.

Care in State hospitals; specialized programs

In-patient programs in state hospitals can offer significant benefits on a long-term basis to chronically or very severely mentally ill children, those with severe brain damage or others who require long-term care and treatment. This is often given in a "closed" setting with special provisions including staff precautions to prevent the child from harming himself or others.

These programs in state hospitals, separate from adult programs, have become more numerous in recent years, as the special needs of children are recognized. In the past, they have been handicapped by a tendency of referring sources to use them as a means of acceeding to community pressures by removing the disturbed—and disturbing—child from the community. The state hospital has unfortunately been used at times by communities to relieve parents, courts, and other agencies of problem children. Referral is still often a matter of expediency rather than the result of clinical judgment and providing the treatment that is most indicated for the well-being of the individual child.

Encouraging reports of new approaches to the care of children and adolescents in State Hospitals, are presented by NIMH (1965). Since the start of the Institute's Hospital Improvement Grant Program (HIP) several years ago, 19 State hospitals have chosen to develop new programs for children and adolescents as their first priority.

In one State hospital the new program for adolescents has forged together group psycho-therapy, ward-patient government, patient discussions, a special therapeutic education school program, individual therapy, occupational therapy and recreational therapy.

In addition to stimulating new combinations of treatment techniques, HIP has opened many new corridors between the State mental hospital and the community. In one new unit for adolescents, the year-end progress report notes that increased coordination with community agencies has occurred and several conferences have been held with County Welfare Boards, Juvenile Commissioners, religious welfare societies, and children's homes. This is an important achievement, since one of the major problems has been the isolation of the hospital from the community, with the result that children have become alienated from the community and lost to the channels leading back into it.

Still another hospital reports that its new project, among other goals, attempts to provide full school credit for work completed while the patient-student is hospitalized. The public school systems within the area have cooperated excellently, the hospital notes, and have been perfectly willing to grant credit for work within the project and to accept the student in the regular school system upon his release from the hospital. The hospital is now working for full State accreditation of the project's educational program.

The Hospital Improvement Program has also contributed to speeding the use of a new educational and psychotherapeutic treatment pattern as the method of choice in childhood and adolescent disturbances. Under this pattern the formative procedures of education are applied to the growth potential of the child at the same time that psychotherapy is used. In the United States this fusion has been called educational therapy or psycho-education. In Europe it is known as orthopedagogy.

One hospital has inaugurated an "accredited therapeutic education" program that fuses therapy and education in a regime of physical education, recreation therapy, bibliotherapy, art therapy, and shop and occupational therapy with a staff at a one-to-one ratio with the children. The hospital reports "a very noticeable change in patient attitude, particularly on the part of the teenager, toward education." When first approached, the typical teenage patient wanted no school work. The hospital thinks this was because his difficulties had created problems in school for him, with the result that he had never had a successful experience relating to education. "We now find the students, without exception, very eager to go to school," the hospital reports, "and becoming rather perturbed when something happens which might either make them late or cause them to lose a day in school. Reports from ward personnel indicate that these individuals, since involvement in the school program, seem much better adjusted with a far better motivation and enthusiasm toward tackling problems, and much better able to conform to the give and take of ward living."

One hospital has established a program that seeks to provide vocational training and to enhance social functioning. Special facilities include a general shop area, welding, print shop, and sewing, typing, and cooking areas. A chief vocational instructor, a social worker, a psychologist, a business education instructor, and a shop instructor have been brought together in a unified staff.

Another innovation is the development of a project under which selected children live in a foster or boarding home and return to the hospital for a day-treatment program.

In yet another State hospital, the director of research has demonstrated methods of providing secondary education for small, carefully screened groups of adolescents. The material came from the public schools and from selected correspondence courses. Films and texts on such life-adjustment matters as personal grooming, manners, and making friends were included, as were newspapers, magazines, and books likely to interest adolescents. Vacations were scheduled to coincide with those in the nearby public schools, thus making it possible for many students to spend these vacations with their families. Marked overall academic and psychological improvement were found. Professional people from other States and Europe have visited the hospital to study the program.

The following recommendations regarding state hospital services for children and youth are made by the American Psychiatric Association (American Psychiatric Association, 1964): 1) The state hospital programs should be seen as an appropriate resource in the general treatment plan for severely disturbed children. Depending on the needs of the state or regional area, the state hospital can provide moderate to long-term treatment, re-education, and rehabilitation. It can also be developed to serve as a day facility, a week care unit, a night hospital, and even as a short-term crisis resource. All such uses of state hospital services should be integrated with other resources in the community. 2) The overall programs should involve the state hospital in explicit roles as to consultative and coordinating services so that it can gradually take its appropriate place in the total community program. 3) Responsibility for the child who is a patient in a state hospital should not be exclusively vested in the hospital but shared by the parents or a designated community agency. 4) Several factors which make for a change in attitude about rehabilitation and discharge should be encouraged. One is a change in staffing patterns with more well-qualified nurses, nursing assistants, child care workers, counselors, and trained volunteers. Another is the growing practice of adequate diagnosis before admission, and a third is the increase in voluntary admissions. One may expect that in the near future the courts will no longer "commit" children to state hospitals because there is nothing else to do with them and that the state hospital will be used only when it is the treatment of choice. 5) The children's unit of the state hospital should have representation on planinng councils along with representatives of social agencies and professional groups. Thus, the state hospital will be active as are other resources in developing a comprehensive program.

Provision for after-care is essential when a child leaves a hospital or residential treatment center. After-care measures should include continued psychotherapy when necessary, educational planning, recreational and vocational guidance, and specific welfare services to the child's family when this is needed. The child should not be sent back to the same problems that gave rise to his emotional illness in the first place. After-care should counteract the tendency of a family, neighborhood, or community to exclude this child and it should help the family to build a healthier environment for him. If the family is not prepared to take the child back, then other placement in the home community should be arranged (American Psychiatric Association, 1964).

EMERGING TRENDS IN TREATMENT

Changes now taking place in the clinical field in models for treatment of mental illness and emotional disorders come from an increasing awareness that social and cultural factors play an important part in the origins and development of psychological problems. Many different treatment models exist today. These models range from behavior therapy which seeks to train people to behave in a more adaptive fashion to classical psychoanalysis with its emphasis on the need to resolve emotional conflicts within the self. It is probable that out of these many different models of treatment, new ones will emerge which make use of theories and methods related to the differing models. Present experimentation reflects a widespread dissatisfaction with past approaches to treatment—there is a general search for a new and unifying perspective on both theory and treatment (Gioscia, et al., 1968; Clinical Issues Committee Report, 1969). Some of the outstanding newer, emerging theoretical models are briefly presented below in summary form. (Many of them do not apply to the treatment of young children, but they are presented because the Commission is concerned with young people up through the age of 24 and with the development of services for parents as well as for their children.)

Newer theoretical treatment models directed toward individuals or groups of individuals

1. The existentialist model in which the therapist engages with the patient in a direct interpersonal relationship addressed to the patient's problems that he is meeting in his present life situation (Laing and Esterson, 1965).
2. Treatment of problems of alienation. The focus is on face-to-face encounters in small groups and on social action addressed to the patient's range of social and economic opportunity. Society rather than the individual is seen as the major focus of treatment (Goffman, 1967).
3. Behavioral model. Emphasis is placed on changing the behavior of the patient through teaching him to act in different ways by the use of planned rewards for desired behavior and over-looking or punishing undesired behavior. One of the theories underlying this approach is that if people behave differently they will have different experiences in their interaction with the environment and thus will begin to feel differently.
4. Paradigmatic model. The patient is helped by engaging in a reenactment or parody of his problematic behavior. Tape recordings, film, and such techniques are used to help the person gain insight through looking at his own behavior. In general, electronic aids are being increasingly used in helping people to view and better understand themselves (Alger and Hogan, 1968; Coleman, Nelson, and Sherman, 1969).
5. Systems approach. This approach is gaining increasingly wide acceptance and is having a powerful influence, both on approaches to treatment and on more basic social planning for the prevention and reduction of mental disabilities and other related problems. According to this theory, the whole system in its operation is more than the sum of its parts because of the effects of the dynamic interaction of its various components. A system is made up of various component levels that include the biological, the psychological, the economic, the social, and the cultural; individuals and families are simultaneously involved in all of these different parts of the total system. Treatment is aimed at dealing with the properties and functioning of the organization of this system rather than exclusively with the experiences of the individual within it. The systems approach is primarily concerned with the behavior of groups and organizations: a system is any organization of elements standing in a patterning relation to each other (Gioscia, *et. al.*, 1968).

For example, a family can be considered as a system. Thus, treatment is directed towards the whole family in terms of its organization and functioning; recently this approach has been extended to include whole clusters of families who are in interaction with each other, to neighborhoods, and the like (Ashby, 1956; Ackerman, 1966; Minuchin and Montalvo, 1967; Speck, 1967).

Systems theory is very closely related to the so-called ecological approach. According to the ecological model, the child is seen as an individual involved in complex interrelationships with his surrounding world, particularly his family. Each unit of the child's "eco-system" is so connected with the whole that any intervention with any part of the eco-system, including individual therapy with the child, will effect the entire system. One cannot intervene in eco-systems successfully without a full understanding of all the processes which serve to maintain balance within the system (Task Force II, 1968).

6. Communications theory is closely related to the above. Confusion in communications is seen as being a major problem in causing and reinforcing mental illness and emotional disorders. Confused communications have been found to be particularly prevalent in familes in which one or more members is schizophrenic. The so-called "double bind" is frequently found in such families whereby a member may give conflicting messages to other members so that a person may be told to to do one thing but the opposite behavior is implied: such as when a parent says to a child, "Do not let me catch you stealing money from your friends." It is implied that the stealing is all right, so long as the parent does not know about it (Bateson, 1962; Reusch, 1961).

Thus, treatment is aimed, in large part at helping patients as individuals or as family members clarify their modes of communicating with each other (Minuchin *et al.*, 1967).

Emphasis has been placed here on the newer approaches to treatment. This is not to infer that they are the current, predominant approaches. Psychotherapy, with its emphasis on person to person interaction between therapist and patient, the development of patient insight, the strengthening of the patient's capacity to deal effectively with reality, is widely used with reportedly excellent results for a sizeable proportion of patients. (See Chapter XII, Research.)

Psychoanalysis is also a major form of treatment and is primarily directed toward helping the patient free himself of deeply repressed unconscious conflicts which stand in the way of his full and effective rise of himself as a person. In the case of the child, psychoanalytic treatment is aimed at resolving conflicts and repressions that stand in the way of his ability to grow and develop along relatively even, harmonious lines. This intensive mode of treatment is generally lengthy and expensive. Psychoanalysts have a major contribution to make not only in terms of the treatment they provide to their necessarily few patients; they also glean significant understandings and insights from their practice which are a valued resource in their work as consultants, teachers and developers of fruitful hypotheses for further research. (See Chapter XII.) Moreover, the more microcosmic, intensive investigations of individuals which are fundamental to the analyst's work provide many of the bases and techniques for therapeutic approaches to children and adults in general.

Re-Structuring the environment

Other theoretical approaches to the prevention and/or reduction of emotional disorders and mental illness put emphasis on seeking underlying causation in the environment and conceptualizing needed related changes. This approach does not necessarily advocate the abandonment of treatment for individuals or groups of individuals, but seeks to reduce the numbers of people who develop disorders which are at least partially associated with environmental stresses and deficits. Some of the related theoretical models follow:

1. Epidemiological. According to this approach emotional and mental disorders are seen as being primarily related to stresses, deprivations, and pressures in the environment. According to this view, emphasis should be placed on locating and changing related problems in the environment rather than providing individual treatment (Laing and Laing, 1961; Kirchoff, 1967; Smelser, 1962). Thus, underlying possible causes are sought in such factors as poverty, racism, poor housing, inadequate education, unemployment, overcrowding, and the like. (See, particularly, Chapters IV, V, IX, and X.)

2. Social pathology. If behavior is regarded as deviant by other people, this puts the individual into a labeled, deviant group and excludes him from society. The problem is seen as not being in the person but in his relation to the social situation. Examples may be found in racist attitudes and practises and in reference to the ways in which our society generally regards and handles children who are labeled as mentally ill, mentally retarded, delinquent, welfare recipients, and the like. These discriminatory attitudes and practises call for social action to change related societal behaviors and attitudes rather than focusing on changes within the individual (Erickson, 1966 and 1967; Silverstein, 1969; Weinberg, 1967).

3. Cultural pathology. The cultural patterns of various groups are seen as playing a part in the origins and continuation of mental and emotional disorders. These patterns arise from the social and economic situation itself and thus social action is required to treat the underlying situation. Involvement of people in planning and carrying out their own programs provides a new individual and group experience which may be effective in changing cultural values and attitudes particularly if this action has an effect on the life situation of the people involved (Chilman, 1966; Rainwater and Yancy, 1967; Riessman, Cohen, and Pearl, 1964).

4. Ethological. Clues are derived from studies of animal behavior in reference to their interaction with the environment and planned manipulation of learning experiences which may have implications for greater understanding of human learning and behavior and the possible consequences of planned environmental change. A great advantage in these studies is that the experiences of animals can be plannfully manipulated and controlled, while this is not generally true in reference to human beings. Although question arises as to the extent to which it is possible to generalize from animals to human beings (Lorenz, 1966), findings from this field are provocative and a rich source of theory for experimental action programs tied to research. (See Chapter XII.)

Some prevalent treatment approaches

Prevalent treatment approaches, aside from those of psychotherapy and psychoanalysis, include:

1. Activity group therapy which was employed at an earlier point and is now re-emerging as a method of treatment along with other forms of group therapy; it is being applied, in a variety of forms, in working with older children, adolescents, and adults, as well as in group activity in therapeutic nursery schools.
2. Group therapy, in general, is being used in many ways, as in the case of interview group therapy for adolescents, group therapy for parents, couples' therapy, and the like.
3. Biological treatment through the use of drugs is now being seen as an adjunct, and not a substitute, for psychotherapy and other related forms of individual and group treatment.
4. The provision of corrective relationships with other people such as providing a mother-substitute for a child whose own mother is unable to meet his needs or the use of foster grandmothers in hospitals. This includes the placement of infants and young children in day care centers and day hospitals.
5. Filial therapy: parents are trained as therapists for their own children and work under the supervision of psychiatric personnel.
6. Home visits and treatment in the home have been found to be extremely helpful but on the other hand they are also exceptionally expensive when carried out by highly trained mental health specialists. However, under supervision, such semi-professionals as homemakers, tutors, and parent educators are showing promising results especially in instances in which the major problem is lack of appropriate stimulation and basic home care of the child.
7. Hospital care is receiving much criticism and out-patient care is regarded as being preferable if at all possible. There are increasing efforts to keep emotionally disturbed and mentally ill children and adolescents in the mainstream of society and in touch with their own families and neighborhoods through a variety of approaches such as group day care, youth hostels, residential treatment centers, day or night hospitals, special schools, increased use of mental health consultation to those who work with children and youth so that the young person can function better in his normal setting, and the like.
8. Environment therapy: in which more attention is paid to the total social-psychological climate in which the person is living; for example, there is increasing recognition that all the people in a child's environment are important to his functioning and self-image—attempts are made to provide a humane, psychologically sensitive and supporting environment in such settings as the school, recreation programs, church-related activities, and so on.
9. Crisis therapy is focused on meeting the problems presented by people at the moment that a crises arises. Twenty-four hour services are recommended along with mobile crisis units (Gioscia, *et al.*, 1968).

Some special projects

One approach to residential and day care for children who are moderately to severely disturbed is Project Re-ED, a cooperative program of the Departments of Mental Health in Tennessee and North Carolina and George Peabody College for Teachers in Nashville. Initially funded for an eight-year period as a demonstration project by the National Institute of Mental Health, the program is now entirely supported by the states as an ongoing part of their mental health programs. To the initial two residential schools serving children age 6–12 (Wright School in Durham and Cumberland House in Nashville), Tennessee has added three more schools, including one for adolescents.

Attractive features of the Re-ED Program are these:

The schools are staffed primarily by teacher-counselors, carefully selected young people with specialized training at the master's degree level—considerably less than the least extensively trained mental health specialist. Selected teacher-counselors are used to provide liaison with the child's home, school, and community.

Pediatricians, psychiatrists, psychologists, and other mental health and educational specialists serve as consultants in the program, thus extending their effectiveness by a substantial factor.

Children go home every weekend, and families and children remain involved with each other in a common effort to learn how to live together. Psychotherapy or classes in parent effectiveness training are available to fathers and mothers.

The schools are ideally located near, but not in university and medical centers, thus reducing costs of construction and occupancy. The cost per child per day is substantially lower than for most intensive residential programs (about $20 to $25 per day), but the great saving is in the length of stay—an average of seven months instead of the usual two years.

Careful follow-up research shows that the program is achieving results equal to traditional programs as reported in the research literature.

This approach is also stressed by Kohlberg who emphasizes that educational attainments are vital to the child's sense of competence and self-confidence. Kohlberg pleads for a "community mental health" or "RE-ED" approach to mental health services. The basic characteristic of such an approach is an orientation to creating an environment in which children are able to develop and grow towards increasing social and educational skills and self-esteem. Children should not be segregated into special therapeutic environments that are radically different from those which they would normally encounter. There should be a general assumption that mental health services are aimed at minimizing the amount of failure, rejection, and misery in a group of children (See, also, Chapter VII) (From a special paper prepared for Task Force II by Lawrence Kohlberg, 1968).

This same general approach is being used in several state hospitals where the trend is to focus on the child's strengths and to establish an expectation for normal behavior and good work habits, to encourage self care and basic social adjustment. Use of child care workers, student volunteers, and retired people with emphasis on small group activities throughout the total program provides more intensive personal experiences and services for the child. The treatment goal is generally that of social recovery and return home as soon as possible (NIMH, 1968).

Partial hospitalization programs vary widely as do the facilities offering them. At Los Angeles County General Hospital, some adolescents spend their days attending school and therapy sessions at the hospital and go home at night. At other centers, adolescents may go to school or to jobs in the community by day and sleep at the hospital. Many visit their homes on weekends and holidays, increasing their home stay as progress permits.

Considerable experimentation is going forward with therapeutic nursery schools for pre-school children who may suffer problems ranging from mild behavior disturbance to severe autism and may require, in addition to individual therapy, a therapeutic nursery school. At one center, a three to four-month nursery school experience for the child is supplemented by group therapy for the parents and by multiple family therapy for some of the families with severely disturbed children.

An NIMH-supported project in Woodlawn, a predominantly low-income Negro area of Chicago, is designed to improve adjustment in first-grade youngsters. The program is made up of weekly classroom sessions with children and their teachers, as well as consultation sessions with school administrators, teachers, and parents. An important feature of the program is the active participation of the community. Neighborhood residents, including parents of the children, are members of the Board of Directors which guides center policy and supports the educational effort. The success of school programs such as these depends on the involvement of key people in a child's life—parents, teachers, physicians, etc.,—in a concerted effort to provide a better environment for all children (NIMH, 1968).

The various treatment theories and methods which have been briefly discussed in the foregoing section have generally received very little systemmatic research attention in order to evaluate their effectiveness. This is also true in reference to the program strategies which have been recommended. Many more well-designed studies are needed in these areas. This subject, along with others related to research needs, will be discussed in Chapter XII.

INTERNATIONAL TRENDS

In many parts of the world there is an increasing interest in the problems of children and youth, a reawakened concern for the mentally retarded, the delinquent, and the disadvantaged. There is renewed interest in group care and protection of the family against the high economic costs of mental disorders and other illnesses.

Broader Social Security coverage and/or mandatory health insurance programs are being established in a number of countries to cover the costs of mental illness.

American visitors are impressed with a growing tendency towards experimentation with many approaches to the planning and delivery of services. In most countries of the world, child mental health services are an integral part of, or closely affiliated with, child health and welfare programs. These are usually seen as being more of a public than a private responsibility. Expenditure of tax monies for children's services is widely accepted. Compared to this country, greater responsibilities and status are accorded child care staff that have limited formal training. Many Europeans believe that the American concern with the costs of services for each individual reflects an out-moded viewpoint which has long ago been replaced in European countries with a combination of mandatory social security and sick insurance benefits.

In many European countries there appears to be more concern with finding practical solutions to immediate problems and less preoccupation with abstract theories and concepts. For instance, there is considerable emphasis on the therapeutic meaning of work and on vocational training of future use to adolescents. Industrial workshops are extensively staffed and supervised and institutional training and work assignments are meaningful. There is no make-do work.

In France and other Western European countries a new kind of professional known as an "educateur" is given considerable responsibility for residential and day care programs for emotionally disturbed and other handicapped children. Some 2,000 educateurs are trained each year in special institutes that provide an intensive three-year course of training, including an internship, that includes some of the understandings and skills of the psychologist, social worker, special educator, and recreational or occupational therapist.

Of course, psychiatrists, pediatricians, psychologists, social workers, classroom teachers and other specialists are involved in treatment programs, and the presence of the educator, trained in near-sufficient numbers, provides a stable, high-quality manpower base not now available in the United States—competent observers report that residential programs for disturbed, retarded, and delinquent children in France are generally superior to those in the United States. A program for disturbed and delinquent children, based on the educateur or reeducation model, has been in successful operation in Montreal, Canada, for twenty years, under the direction of Mlle. Jeanne Guindon. The closest counterpart in the United States is the reeducation programs of Tennessee and North Carolina.

In sharp contrast with current United States practice are those social welfare oriented and/or collectivist societies which have established central planning, state directed coordination of services, and some control over manpower training and placement, coupled with a strong tradition of comprehensive social security and sick benefit insurance coverage. Examples might range from the more moderate programs of the Netherlands and the United Kingdom through the Scandanavian countries and Israel, to the managed economies of the Communist lands of eastern Europe.

Reports prepared by the 1968 U. S. Mission on Mental Health to the Soviet Union indicate that there is an elaborate array of child caring services in this country. These services include group care for infants, nursery schools, boarding schools, and invalid homes. Children are cared for days, evenings, or on a residential basis. After the mother delivers the child, the district children's clinic is immediately notified by the hospital. These clinics are the medical center of all services for children; there is one in each district serving approximately 15,000 children. These clinics also provide most of the medical and psychiatric services for kindergarten and school youngsters, including physical and psychological examinations.

The Soviet child is not lost in a welter of agencies. The district children's clinic is home base. This clinic has a number of staff specialists including those in pediatrics, child psychiatry, and speech therapy. At age 16, the adolescent and his records are transferred from the child's clinic to a special clinic for adolescents. At age 18, his records are transferred to an adult service. Continuity of service to people of all ages is thus maintained.

Health care services in the Soviet Union are closely related to basic goals which includes the provision of a coordinated network of preventatively oriented, readily available, and geographically accessible mental health services, free of cost for all Soviet citizens. This is a reflection of the principle that health is a resource of the state, no less important than other natural resources, from which, it follows, that good health must be maintained and ill health prevented. In that sense, there is in the Soviet Union, unlike the United States, a clearly defined and explicit relationship between the structure of the government and the organization and delivery of health services.

The principle of continuity of care in the Soviet Union also includes provision for after care following discharge from a hospital or other child care facility. Few if any U.S. states have mandatory provisions requiring clinics with state aid to provide follow-up care to patients returning from state hospitals or residing in their service areas.

Although more data are needed to evaluate the impact of these programs, there is little doubt but that child welfare is recognized as an important matter in state planning in Communist countries. Based on public health principles, emphasis is given to those forms of prevention and treatment which can be applied rapidly, widely, and inexpensively. Many of these same trends have also taken place in such countries as Israel, the United Kingdom, Denmark, Norway, and Sweden (David, 1969).

SUMMARY AND CONCLUSIONS

The great majority of emotionally disturbed or mentally ill children and young people in the United States fail to receive needed diagnoses, care and treatment for their problems. It is estimated that .6 percent are psychotic and another two to three percent are severely disturbed. An additional eight to ten percent have serious emotional disorders. The severity of this problem is bound to grow because of the increasing numbers of young people in the population and because the biological and social stresses of today's society are likely to increase the rate of emotional and mental disturbances.

We are faced, as a nation, with a host of critical problems in respect to these handicapped youngsters. These problems are the most poignant and acute for them and the members of their families, but these problems, further, are of concern to us all: both in human and economic terms.

For such children, from moderate to extreme degrees, are crippled in their ability to learn, to relate to others, to see the real world as it is, to adequately handle their impulses of anger, fear, sex interest, and the like. Some, in their sense of helplessness, confusion and rage, strike out at society in destructive acts. Others retreat mutely into a world of tortured imagination far from the reach of other human beings.

The problems of these unhappy youngsters are baffling indeed. There is a great deal that we do not know about them: exactly how many there are, the extent to which they are more likely to belong to families that suffer the stresses of poverty and/or discrimination, the causes of their problems, the ways in which they may be most effectively treated. Much, much more research is needed to learn the answers to these difficult and important questions.

In the meantime, while seeking and awaiting these answers, we do know that much can be done and must be done to care for these youngsters and to lighten the burdens that are placed on them and their parents. We know that no community in the United States has all the facilities for the care, education, guidance, and treatment that such children need. We do know that the few available facilities are poorly coordinated, one with another, that they are frequently unavailable to the poor and near-poor, that many emotionally and mentally disturbed youngsters are falsely diagnosed and institutionalized as being retarded or delinquent, that thousands are losing all possibility for partial or full recovery because they are forgotten and left to slowly deteriorate on the back wards of mental hospitals, and that mental health facilities and manpower are much more likely to be devoted to the needs of adults than to the needs of the child and youth population.

Further, we know that many children and adolescents with minor emotional and learning disturbances recover fully if they are given understanding guidance and help, that other more seriously handicapped young people improve with appropriate treatment, that a few show no improvement despite the best professional efforts, but that assuredly they need humane care and their parents need help with their heavy responsibilities.

We know more than this. We know that children and young people with emotional and mental disorders are happier and more likely to improve in their behavior if they are kept in their own homes or, at least, in their home communities or, if this is impossible, in close touch with their families and communities.

We are becoming increasingly sure that emotional and mental disorders probably represent a number of dysfunctions operating differently for different individuals. These dysfunctions cover a wide range, from slight to moderate to severe. Many of these dysfunctions probably originate in the biological structure and functioning of individuals, but the form and severity of these disorders are affected by the many, interacting factors in the child's experience and environment in terms of his own developmental stage, his family, neighborhood, school, medical resources, church or synagogue, and the like. In most, if not all, instances of these disabilities, the child's problems are the result of a complex of factors, and his effective care and treatment depends on a complex of appropriate, coordinated services based upon expert diagnosis of his problem by a professional team of psychological, social, and educational specialists and periodic team assessment of his condition. In these diagnoses and assessments the central question should be the child's level of physical, social, intellectual, and emotional functioning in terms of his particular developmental stage and in a particular social setting.

In order to appropriately care for these children and young people, a whole network of diagnostic, treatment, and care facilities must be available including: a service information and referral center, physical and mental health clinics with special services for children and youth, mental health and special educational services in the schools, day care and homemaker services with mental health consultation and supervision available, half-way houses for disturbed adolescents, residential treatment and other forms of group care centers, special child and adolescent units in psychiatric hospitals, vocational rehabilitation and protected work situations, and family counseling services. Not only should these services be closely coordinated but it is imperative that arrangements be made for the sustained, continuing care of these children and their families.

Of particular importance is reaching parents at a very early stage; before conception, if possible, with genetic assessment and counseling in those instances in which there is reason to suspect that a biologically handicapped child may be born. Excellent medical care during pregnancy, at child-birth, and in the following early years of life is crucial, as we have recommended in other parts of this report. Emotional and mental problems in infants and toddlers, undetected and untreated, are likely to grow in severity and become increasingly difficult to reduce or erase as the child grows older and his faulty perceptions and behaviors become increasingly rigid and entrenched.

Specialized services for children with emotional and mental disorders should be planned and administered as part of a larger community program which is directed towards meeting the health, educational, recreational, housing, employment, social and economic needs of all of its citizens at all age levels. Mental health services for children are an important, but not distinct, segment of a total community program which fosters the healthy growth and development of all individuals and families; for the emotional and mental well-being of any child is intimately and intricately related to the emotional and physical health of the members of the community in which he lives.

At present, there are many different approaches to the treatment of disturbed children, ranging all the way from an emphasis on teaching more effective forms of behavior to classical psychoanalysis with an emphasis on resolving emotional conflicts within the self. Experimental new theories and treatment methods are emerging which offer promise for the future. It is important that these different approaches be carefully evaluated with well-formulated research.

In many parts of the world there is a reawakened concern for the problems of mentally retarded, disadvantaged, delinquent, and emotionally disturbed children and youth. There is a growing tendency in many countries for the inclusion of public child mental health services as a part of child health and welfare programs. These are often financed by comprehensive social insurance arrangements. Unlike the United States, many nations increasingly provide comprehensive, continuous, coordinated care of all kinds to all children from conception on through infancy, childhood, and youth. While data are not yet available to assess the impact of such arrangements, there can be little doubt that these nations are pioneering in important programs that should command our serious consideration.

Period and age	Psychosocial tasks (crises)	Psychosexual stages	Radius of significant relations	Central value orientation	Stages of intellectual development
Infancy:					
Birth	Trust versus mistrust (I am what I am given).	Oral-respiratory, sensory-kinesthetic (incorporative modes).	Maternal person	Hope	Sensory-motor: The infant moves from a neonatal reflex level of complete self-world undifferentiation to a relatively coherent organization of sensory-motor actions. He learns that certain actions have specific effects upon the environment. Minimal symbolic activity is involved. Recognition of the constancy of external objects and primitive internal representation of the world begins.
3 months					
6 months					
9 months					
1 year					
18 months	Autonomy versus shame, doubt (I am what I "will").	Aral-urethral muscular (pretentive-eliminative modes).	Parental persons	Will	
Preschool:					
2 years					
3 years					
4 years	Initiative versus guilt (I am what I imagine I can be).	Genital locomotor (oedipal) (intrusive, inclusive modes).	Basic family	Purpose	Preoperational thought (prelogical): The child makes his first relatively unorganized and fumbling attempts to come to grips with the new and strange world of symbols. Thinking tends to be egocentric and intuitive. Conclusions are based on what he feels or what he would like to believe.
5 years					
6 years			Neighborhood school		
School age:					
7 years	Industry versus inferiority (I am what I learn).	Latency		Skill	Concrete operational thought: Conceptual organization takes on stability and coherence. The child begins to appear rational and well organized in his adaptations. The fairly stable and orderly conceptual framework is systematically brought to bear on the world of objects around him. Physical quantities, such as weight and volume, are now viewed as constant despite changes in shapes and size.
8 years					
9 years					
10 years					
11 years		Puberty	Peer in-groups and out-groups.		
Adolescence:					
12 years	Identity versus identity diffusion (I know who I am).	Early adolescence	Adult models of leadership.	Fidelity	Formal operational thought: The individual can now deal effectively not only with the reality before him, but also with the world of the abstract, propositional statements and the world of possibility ("as if"). Cognition is of the adult type. The adolescent uses deductive reasoning and has the ability to evaluate the logic and quality of his own thinking. His increased abstract powers provide him with the capacity to deal with laws and principles. Although egocentrism is still evident at times, important idealistic attitudes are developing in the late adolescent and young adult.
13 years					
14 years					
15 years		Middle adolescence			
16 years					
17 years		Late adolescence			
18 years					
Early adulthood	Intimacy versus isolation.	Adulthood (genitality)	Partners in friendship, sex competition, cooperation.	Love	
Middle adulthood	Generativity versus self absorption or stagnation.	Maturity	Divided labor and shared household.	Care	
Late adulthood	Integrity versus despair, disgust.	Menopause, male climacteric, genescence.	Mankind, my kind	Wisdom	

"The First Three Years of Life: An Overview of a New Frontier of Psychiatry" by Reginald S. Lourie, M.D. From PP 33–39, American Journal of Psychiatry 127:11, May 1971*

Psychiatry must become more concerned with the first three years of life if the roots of later pathology are to be identified so that preventive measures can be undertaken. In this overview the author interweaves newer information with what is already known about early development. He includes the concept of "organizers" in the infant's experience, which form the beginnings of integration of functions; these include vision, pain, separation anxiety, body image development, learning of body control, and exploration of property rights.

My task in this report is to bring more clearly into focus what is slowly but predictably becoming the new frontier of psychiatry—the first three years of life. It has been summarized as the task of helping a small, helpless, mindless being become "humanized," a member of society, an individual in his own right, and to develop so-called civilized patterns of control over his impulses(1).

The recently completed studies by the Joint Commission on Mental Health of Children (2) indicate that if we are to ever think of an era of prevention in the field of mental health, we must become increasingly involved with the relatively neglected first years. Such involvement is necessary not only in our understanding, treatment, and prevention of disordered behavior, i.e., in dealing with mental illness and the promotion of mental health. It is also necessary if we are to respond to the major problems facing our communities and nation such as violence and crime; racism; the nonlearners who become the unemployed; and the personality characteristics of hopelessness, helplessness, passivity, dependency, apathy, alienation, suspiciousness, and depression in our Inner Cities.

We have known for a long time that the roots of many of these major problems are in childhood, but more recently we have been forced to look at how early—when even Head Start programs have been found to be too late for many of our young. This survey will attempt to interweave the newer information with what we already know about what goes on developmentally. It interweaves "hard" and "soft" facts, but at this stage of our information if we disregard the "soft" facts we close doors that can lead to more knowledge.

PRENATAL STAGE

If we are to start at the beginning of life for our understanding of normal and abnormal development, we must start measuring age, as do the ancient Chinese, from the date of conception. In other words, a baby is usually nine months old at birth. Embryology has gone out of fashion in many of our medical schools, but a new type of behavioral embryology is evolving and must eventually be included as a basic science for psychiatry. At this point in our information, we have only hints about the earliest stages the brain-body interactions go through. We can recall that Freud pointed out (3) (to the discomfort of some current psychoanalytic theoreticians) that by the time of birth it is already established what the predominant defensive patterns of the individual will be—for example, whether they will be predominantly hysterical or compulsive.

We do not go as far as Gilbert and Sullivan did when they wrote that every man now alive was born a liberal or conservative. But the finger increasingly points to the prenatal period to help us understand the psychosomatic problems of later life. We must ask ourselves when it is that an organ or an organ system develops a pattern of reaction to stress. Is it when there is acute or chronic stress during its formation that a pattern of response is established, such as when the oxygen supply is suddenly threatened? Does this imprint the kind of response that organ or system will make when later stress is encountered?

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*Based on a paper read at the Third Annual Seminar for Continuing Education for Psychiatrists, Atlanta, Ga., Feb. 12–15, 1970.

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We are learning that pathological or potentially destructive defensive responses, such as those that would result in hypertension, can be modified or retrained later; this has been demonstrated by some of the behavior modification techniques being developed at Rockefeller University. I hope the day will come when we can understand the combinations of genetic, metabolic, and environmental influences (Can we talk of the social life of a fetus?) that determine such patterns of functioning. What determines in these first nine months of life the nature and dosage of aggressive energy in any individual?

Thus far there have been postulated a socalled "umbilical stage" (4, 5), when the hematological system learns a pattern of response to stress (we cannot yet say anxiety) and a "deglutitive stage," when the fetus first learns to swallow, etc. So we are on the verge of finding answers to some of these questions. There are increasingly ingenious devices for interventions directly into the uterus that will permit monitoring and eventually corrective approaches with the fetus. At this point in time it is postulated that the major single determinant of what kind of fetus we are dealing with is the nutritional state of the mother at the point of conception (6). Are we on the edge of a change in the dating patterns of our youth in which every date must include a good meal?

THE NEWBORN

Once born, the individual enters a period in which the brain will grow more rapidly in the next 18 months than it ever will again. The inputs during this period of brain growth begin to build on the foundations begun in prenatal life. This is the time when the brain is most plastic and when appropriate interventions to correct pathology can be most effectively made. The experience of our British colleagues working in the field of cerebral palsy illustrates this point (7). They have found that with appropriate diagnosis and active treatment in the first 18 months of life, when the brain is most plastic, they can prevent most of the spasticities and the skeletal deformities such as the kyphoses and can even eliminate the athetoses.

Information is becoming available from work not only with animals but also with human infants that indicates, as Negera (8) has pointed out:

1. The genetic potential, in terms of the development of the anatomical structures of the brain, is not reached at birth. Many such structures are in fact far from complete at such a time.
2. The blueprint of that genetic potential (determined by the chromosomes and genes) is such that in order to be unfolded to its fullest, organic, anatomical-maturational processes of the brain structures must continue after birth. But such continuation is not only dependent on internal, embryological maturational forces, but—and this is what I want to highlight—in the interaction of such forces with different forms of external stimulation without which interaction the embryological maturational blueprint will not unfold to its full potential. Reception of such stimuli, as contained in the ministrations of the mother to her baby, in the mother-child relationship, seems absolutely necessary. Furthermore, this kind of external stimulation seems to influence the internal, anatomical-maturational processes at least by three different mechanisms:
   a. It may favor progressive complex arborization of dendrites during the first few months of life. The significance of this in terms of later function is clear.
   b. It increases the degree of vascularization of certain anatomical structures of the brain.
   c. It increases and furthers the process of myelinization. Myelinization and function are closely related, as we know.

Studies in kittens blindfolded from birth most dramatically demonstrate the contrast in vascularization and myelinization in the visual cortex and the tracts involved. It seems to follow that modifications that result from inappropriate or inadequate environmental stimulation lead to modifications of the developing brain structure that may lead in turn to important qualitative differences in the ability to perform all the ego functions associated with such structures.

We also know from embryological studies in animals and humans that there are critical periods for the development of specific organ functions; that is, developmental time limits exist, and if the right type of stimulation is not forthcoming during that critical time, the result may be a structure not necessarily damaged but one that has not developed to its full potential. This type of information begins to explain the problems of hospitalism as defined by Spitz, who described it as "the appalling damage to early ego development that results from growing up under conditions of deprivation or inappropriate types of human contact" (1, 9). Resulting developmental lags can be undone, which indicates to some of our investigators that we cannot talk of *critical* periods of development for the human but rather *optimal* periods (10). However, the evidence strongly suggests that the individual can never completely recapture his original potential once the optimal period for development of a part or a function has passed.

The major developmental stages from birth to maturity are well documented (11, 12). Our information in this area, which comes from child development research, psychoanalytic theory, and clinical studies, is more complete. But we should realize that the psychoanalytic formulation of oral, anal, and the beginning of phallic stages of development in the first three years describes only headlines. If we look at the fine print, we see dozens of stages—at least one for every new part of the body as it comes into voluntary control and for every new function as it develops. Each new part is experimented with in terms of "How can this new found part of me be used in the service of the instincts?" i.e., for survival, for pleasurable use, for aggressive expressionism. This holds true for each of the ego functions. We understand some of these, such as cognitive development (to which Piaget [13] and many others have made important contributions) better than others.

Even as we have established at least some understanding of the stages through which the young organism goes in the development of personality, we are only beginning to look at them in terms of their influence on individual differences in constitutional makeup. For example (taking the most important first step in personality development), as perception and awareness develop the baby moves from a relatively unrelated stage at birth to a picture of himself as a completely dependent part of another person; this normally occurs by three to five months (see figure 1). If something intervenes that makes this step difficult to achieve, a range of distortions in the individual's concept of dependency, closeness, and trust can result. At one extreme of this range is the child who says it can be too difficult or uncomfortable to make this step and he elects to remain unrelated, i.e., he becomes autistic and later develops a childhood psychosis, if the condition remains unmodified.

Developmental Distortions

Particularly within the last 20 years, we have come to recognize that there are a number of constitutionally based developmental distortions early in life that lead to the individual differences that can place an infant at risk in making this first step in emotional and personality development (14). If we match up constitutional vulnerabilities with assets, we will have a much better picture of how a baby needs to be handled to help him achieve optimal development, beginning with object relationships.

To illustrate, let us look at the problems faced by babies born with special hypersensitivities. Tactile hypersensitivity—experiencing being touched as painful—provides a hazard to being comfortable with closeness and to seeing oneself as part of another person. If the baby does not elect to remain unrelated, if the need to be part of another person is sufficiently great, he will make the first step. However, the resulting picture can include a long-lasting expectation that dependency involves pain. Since dependency is part of most close relationships, masochism can have its beginnings here—or, to put it another way, primary masochism can be perpetuated. Some individuals can carry this a step further and say that pain is not only a need, it is also a pleasure.

On the other hand, if this individual distortion in makeup is recognized early and properly handled, it will not interfere with normal early development; usually it is compensated for so that before the end of the first year it is no longer clinically evident. For example, one mother, when her baby's hypersensitivity was pointed out as the basis for his irritability and his turning away from her, said "Let me put him on a pillow and hold the pillow when I feed him, if it is important for him to have closeness. That doesn't make him uncomfortable." In contrast to this is a ten-year-old girl in our treatment school who never can let anyone touch her and is mistrustful of any dependency situation; she started life as this kind of baby.

TAKING STOCK OF THE INFANT

It is now possible to take an inventory of constitutional factors early in life so as to devise methods of handling that can help prevent poor answers to the problems of early personality development. We can take note of imbalances, deviant arousal patterns, low energy and "sending power," labilities, disturbances in integrative capacities, the threshold for stimuli, special sensitivities, and structural difficulties. Essential in any such inventory is taking stock not only of the handicaps or functional distortions but also of the baby's assets. Thus we rate adequate sending power, curiosity, and flexibility as measured by the ability to provide substitutes, fend off pressures, turn away, alter the environment to organize, protect the self, and get needed help or support. We want to know about persistence, determination, usable antennae, and stable somatic integration. I have found Lois Murphy's Vulnerability Check List (15) the most useful means of assessing the potential areas of difficulty in young babies, as well as the positive components.

It used to be said that children with gross defects received the most attention, while those with milder or minimal distortions often had to wait until school age before their handicaps were recognized. More recently, it has been recognized that the blind, the deaf, and the cerebral palsied and otherwise brain-damaged child not infrequently present multiple handicaps that also may be overlooked because emphasis is placed on the major presenting problem. Fraiberg's work with blind babies illustrates this well (16). The athetotic cerebral palsied child who is trying to gain control of arm movement can be frustrated by a tendency to perseveration. The deaf child with hyperactivity may not be able to sit still or to concentrate long enough to find other communication patterns.

It may take only one major handicap to influence ego development, but we more often find a combination of minor ones that can frustrate the compensatory efforts of the organism to be as "normal" as possible. A passive child with a perceptual hypersensitivity to light, sound, touch, temperature, or pain cannot cope with stimuli that other babies could avoid. The hyperactive baby may on closer scrutiny be presenting an imbalance: his motor drives may be stronger than his coping devices or his capacity for love to bind them. This in turn can lead eventually to impulsiveness, destructiveness, and aggressiveness. One of the most difficult vulnerabilities to identify in early life is the tendency for thinking and coordination to become disorganized under stress. This becomes evident in the form of disorganization of motor activity. The stress situation in turn may also be related to other vulnerabilities in constitutional makeup, such as a low threshold for displeasure, hostility, or anxiety. The end result can be a feeling of helplessness, which is the worst feeling in the world. In contrast is the baby who becomes better organized under stress, like the clutch hitter in baseball. It is felt that this tendency is built into the organism at birth.

The purpose of identifying these individual differences in constitutional makeup (often described as components of the autonomous ego) is to insure the healthiest possible development of the rest of the ego functions. The child should be helped to develop an optimistic attitude and a positive approach to problem solving; the purpose of cataloguing this information is to help parents to be aware, to recognize the problem, to step in and assist in correcting the anxiety-producing situation. Likewise, in the case of the infant who is too compulsive and cannot shift away from a subject, the availablity of someone who can change the scene or mood helps him develop a wider range of affect, more capacity for fun, joy, interest in new experiences, play, and ultimately creativity.

With a passive, low-energy infant outside help and stimulation are needed if he is to be enabled to overcome his initially poor capacity to exert effort, to struggle against obstacles, and to keep on trying after a failure. Picture what happens if this baby has unaware or unavailable parents—parents who are so passive themselves that they cannot reach out to the child when he is unable to indicate his needs or demands.

The development of the sense of reality requires experience with and selective use of the environment. The child with preceptual-cognitive maldevelopment, for example (as in the much-abused concept of minimal brain damage), has difficulty in acquiring correct concepts of objects, space, time, etc., under certain conditions. These will occur, for example, if anger and frustration overwhelm him—if he has no outlets for discharge or mastery over his anxiety and no recognition of what he is struggling with, and if his caretakers have no recognition of the nature of his struggles.

The concept of self and body image can also be distorted under such conditions. The hyperactive child whose caretakers do not realize that he cannot stop himself and that he needs their help in putting the brakes on is particularly subject to distortions in these areas. He must avoid the feeling of helplessness at all costs. When a poorly controlled pat becomes a slap, he says "I wanted to hurt." When he inadvertently knocks a glass off the table, he says, "I wanted to break it." Yet underneath these defenses he has a very poor opinion of himself. If this continues, he has a good chance of being a depressed, self-defeating school-age child and adolescent.

It is apparent that almost endless combinations of weaknesses, handicaps, strengths, and resources are possible. If we look closely we can find in each child his own unique combination. That many infants solve the problems posed by potential handicaps in the process of maturation and regulation is evident from the ones who seem to "grow out of it," i.e., whose developmental delays are overcome. In the National Institute of Neurological Diseases and Blindness collaborative study of pregnancies, births, and early childhood, 25 to 30 percent of babies in some cities were found to have evidences of neurological damage. But with proper handling, at the end of the first year only ten percent still showed such evidence. This ten percent is the group most vulnerable to poor solutions in earliest personality development. That many infants can carry these poor solutions into later childhood and even adult life is also evident.

THE CONCEPT OF "ORGANIZERS"

It has been pointed out that at the beginning of life there is no connection among the senses. They need to become coordinated and integrated to optimally negotiate the development of the ego functions, of memory, reality testing, the ability to think abstractly and to fantasy, to develop curiosity. In other words, there are "organizers" in the infant's experience. These form the beginnings of integration of functions and the development of the structural foundations that establish them for the rest of an individual's life. A major one is vision(1). Another organizer that we are finding out about is pain. However, to answer those who think only mechanistically about such developmental processes, there is evidence that affect must accompany the provision of stimuli in order to have effective ego development. It is the affect that makes it a fundamental educational experience and one that is permanent. Inputs without affect result in learning that is impermanent unless it is repeatedly reinforced.

Thus far I have concentrated on the newer dimensions that are important in the first steps in personality development, particularly as they throw light on the areas we should keep in our awareness in the interest of a healthy evolution of trust and dependency in object relations. There is no need to review the information available about the later stages of personality development in the first three years except to highlight the newer information that can be added to our understanding of the importance of selected stages.

The baby at an average of eight months is able to see himself as slightly independent when it is able to crawl away from its mother and to identify strangers and strange places; this stage of separation anxiety thus becomes another personality organizer. Inappropriate solutions to this first phase in the development of independence have been implicated as the precursors of later depressions(17), as well as to the persistence of fear of strangers and anxiety in the presence of anything new or different. More recently this stage has been implicated in the onset of leukemias(5), lymphomas, and lupus erythematosis(18). One type of poor handling in this stage has also been pointed to as responsible for a developmental defect that can be utilized later as a motivation for suicide. Thus when a baby, to demonstrate that it is not helpless when left by its mother, turns away from her and finds that his leaving or "getting rid" of her is a way of hurting her, it has learned an important lesson. There is an element of this kind of thinking in most suicides, i.e., thinking how the people left behind will feel(19).

The second and third years of life are very busy ones in terms of personality development; character formation proceeds actively and much of it simultaneously, To apply the concept of organizers to a few highlights in these years:

- The stage of negativism is an organizer of the will.
- Body image development is an organizer of self-respect. An important current problem in this area is the development of racism. When we ask at which ages a child begins to look at itself and ask "Is black or white or red or yellow good or bad, is it clean or dirty, is it beautiful or ugly?" we find it is in the third year of life that the first and often most important answers are established.
- Toilet training is one example of the processes of learning body control that are organizers of the individual's control system. This type of control is most actively developed in the second year of life and becomes integrated with the process of control over impulses. Inappropriate models provided for the child in the handling of aggressive impulses, particularly those that are overstimulating or distorted, can complicate this multidetermined process of "civilizing the drives." Violence as a way of life can have its beginnings here.
- As part of moving through further stages in the development of independence, another organizing process centers around exploration of property rights, "what's mine and what's yours." This becomes integrated with respect for rules, moral values, respect for privacy, territoriality, etc. The groundwork is laid here and in the control system for later delinquency. Later the lessons learned are carried into the exploration of "who is mine and who is yours."

CONCLUSION

These few examples indicate how those concerned with the problems of human behavior must be concerned with the first three years of life if the roots of later pathology are to be identified in the interest of prevention and early modification. Poor answers in the early stages can complicate later stages and lock in place poor problem-solving techniques, patterns of reaction, and fears. They can lead to a closure of lines of development; a preoccupation with avoidance of discomfort, with emphasis on immediate pleasure; a poor self-concept; and many other possible distortions. We can recognize these as elements of personal malfunctioning later in childhood and indeed, in too many individuals, for the rest of their lives.

The purpose of this overview is to indicate that psychiatry and particularly child psychiatry have neglected the time in the life cycle when they can most profitably open a new frontier. Our training programs have not been concerned with the problems that are available for solution in the first years of life. Nor have we developed the necessary partnerships with those who have been concerned with this time of life. Let us move to fill this gap.

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Statistical Note 24

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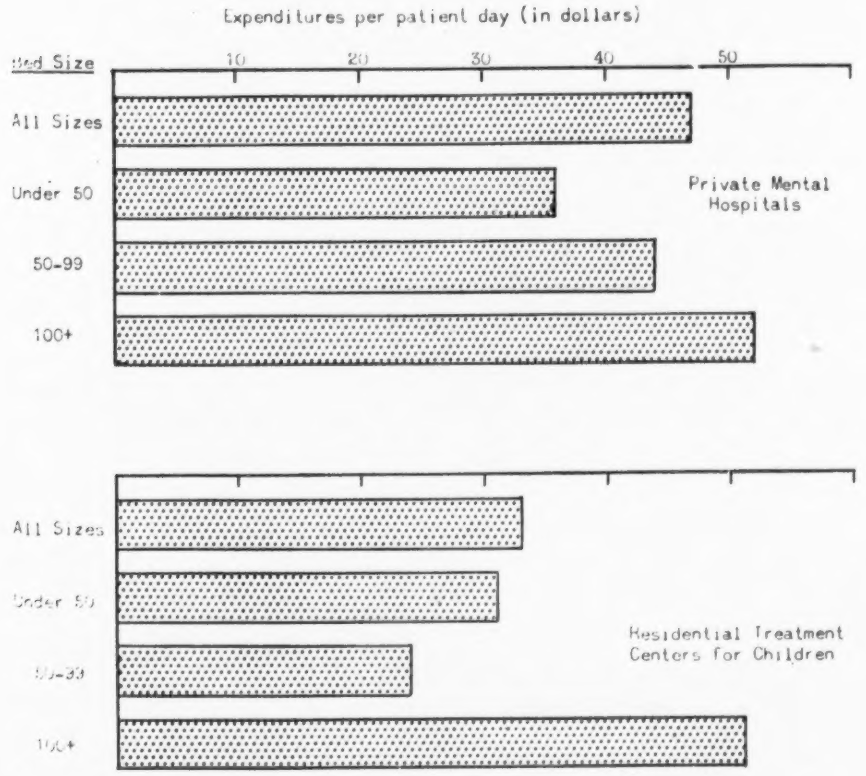
EXPENDITURES IN PRIVATE MENTAL HOSPITALS AND RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN - 1968



May 1970

Carl A. Taube

("Residential Treatment Centers for Emotionally Disturbed Children—1968"—Statistical Note 11; and, "Expenditures in Private Mental Hospitals and Residential Treatment Centers for Emotionally Disturbed Children—1968"—Statistical Note 24 by Survey and Reports Section, Biometry Branch, Office of Program Planning and Evaluation, N.I.M.H., DHEW)

RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN—1968

In addition to the public and private mental hospitals and institutions for the mentally retarded for which statistics have been collected over the years, there is another group of facilities which serve emotionally disturbed and/or mentally retarded children. These latter facilities, identified under the general label of residential treatment centers, either could not or preferred not to be classified under any of the other types of inpatient facilities and, heretofore, were not included in the national reporting system. Provisional data for these centers, now available from an Inventory of Mental Health Facilities conducted in January 1969, are presented in this report. These data, together with more detailed tabulations to be available in the near future, may help to clarify the distinction between residential treatment centers and the public and private hospitals and institutions serving predominantly children which has never been clear-cut.

Data from the current Inventory indicate that there were 188 residential treatment centers for emotionally disturbed children, mostly private and non-profit, serving an estimated 26,000 children during 1968. This number represents approximately five percent of the children estimated to be under care in various types of inpatient and outpatient psychiatric facilities.[1]

These facilities, defined as residential institutions that primarily serve children who by clinical diagnosis are moderately or seriously disturbed emotionally and provide treatment services usually under the supervision of a psychiatrist, offered a various range of services, as follows:

Service:	*Percent of total facilities providing service*
Inpatient care	100
Outpatient care	29
Day care	18
Night care	2
Aftercare	41
Emergency service	8
Diagnosis and evaluation	49
Rehabilitation	38
Preadmission service	51
Research and evaluation	15
Training	38
Other	16

The predominant service modality was, as might be expected, inpatient care, with all of the centers offering this service. However, almost a third of the centers also provided outpatient services and about one-fifth provided day care service. In addition, a variety of other services were seen to be offered by varying numbers of these facilities.

Information on the estimated caseloads experienced by three of the patient care services—inpatient, outpatient and day care—presented below, indicates that the number of additions and discontinuations during the year for inpatient care were about equal resulting to no significant change in the resident population at the end of the year among the centers surveyed. Caseloads for day care and outpatient care, however, showed some slight increase during the year.

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[1] For estimates of the number of children under care in other types of psychiatric facilities see *Utilization of Psychiatric Facilities by Children*, National Institute of Mental Health, Mental Health Statistics, Series B, No. 1, U.S. Government Printing Office, Washington, D.C. 20402

Caseload	Inpatient care	Day care	Outpatient care
Persons receiving direct services at beginning of year	9,569	311	4,648
Additions to direct service during the year	5,655	289	5,652
Patients under care during year (Sum of 1 and 2 above)	15,224	600	10,300
Discontinuations from direct service during the year	5,652	268	5,414
Persons receiving direct services at end of year	9,572	332	4,886

As of January 1969 an estimated 10,775 beds were available in the inpatient care services of these centers—this averages to about 57 beds per facility. Owing to a smaller average inpatient caseload per facility, the average occupancy rate was 89 percent during the year.

Total expenditures incurred by these centers during 1968 amount to slightly over an estimated 98 million dollars, or an average of $524,000 per facility. The proportions of this total allocated for operating expenditures and for salaries were respectively higher and lower than similar proportions shown for other types of mental health facilities. (See Table A, *Statistical Note 5*)

Type of expenditure	Amount in thousands	Percent
Total expenditures	$98,350	100
Salaries	54,522	56
Other operating expenditures	31,807	32
Capital expenditures	12,021	12

Expenditures in Private Mental Hospitals and Residential Treatment Centers for Emotionally Disturbed Children—1968

Data collected in the January 1969 Inventory of Mental Health Facilities indicate that the expenditure per patient day in private mental hospitals is less than that reported for general hospital inpatient psychiatric care. The average expenditure per patient day reported for 72 private mental hospitals [1] for calendar year 1968 was forty-seven dollars. Reported expenditures in general hospital psychiatric units are in the range of 50–60 dollars. The attached table shows annual expenditures and per diem expenditures by size of the hospital.

Similar data for Residential Treatment Centers for Emotionally Disturbed Children [2] are given by bed size in the attached table. Since 106 of 114 [1] reporting facilities are non-profit, no breakdown by ownership is given. A previous Note [3] presented utilization data on these facilities and provided estimated expenditure data for the 188 known facilities.

The reader is cautioned that these are average figures based on the overall experience of the facilities responding. The costs for any given facility may be higher or lower, depending on such things as the population served, services available, composition of staff, treatment policy (short-term or long-term, for example) and many other factors.

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[1] A potential source of bias is that these data are based on reports from a low proportion of the facilities relative to the total number known to be operating. Because of the paucity of such data and the urgent need for these data, these figures are published in this provisional format. The reader is cautioned that these figures are subject to change at such time as more completely reported data are available.

[2] Defined as residential institutions that primarily serve children who by clinical diagnosis are moderately or seriously disturbed emotionally and provide treatment services usually under the supervision of a psychiatrist.

[3] Statistical Note 11, "Residential Treatment Centers for Emotionally Distrubed Children—1968" Biometry Branch, OPPE, NIMH, November 1969.

"Residential Treatment Centers for Emotionally Disturbed Children—1969-1970" D.H.E.W. Publication No. (HSM) 72-9022

INTRODUCTION

In this report, residential treatment centers for emotionally disturbed children (RTC's) are defined as institutions providing inpatient services, usually under the supervision of a psychiatrist and primarily to persons under 18 years of age, who by clinical diagnosis are moderately or seriously emotionally disturbed. Some mentally retarded children may be served in RTC's. However, facilities which serve primarily the mentally retarded are excluded.

It is important to recognize that each of the 261 facilities in 1969 which fulfilled this definition is unique in terms of such characteristics as its philosophy, origin, approaches to care and treatment, utilization of staff, range of services, intensity of care, relationship of staff to children, living arrangements, etc. A statistical study, as presented in this report, cannot reflect adequately the uniqueness of the programs conducted in each facility. For an in-depth description of selected RTC's, the reader is referred to two reports prepared by the Child Welfare League of America, Inc.[1,2]

In addition to the current report, there have been several other statistical reports, which have presented data on RTC's. The results of a census of children's residential institutions in the United States in 1966, published in the *Social Science Monographs* series of the University of Chicago, include a volume on "Institutions for Emotionally Disturbed Children."[3] Publications by NIMH on RTC's include two *Statistical Notes,* which present provisional data for 1968.[4,5] Another NIMH report, which is based on data for January 1968, compares staffing patterns in various types of mental health facilities (including RTC's).[6] This current report for 1969 is the first NIMH report which presents comprehensive data on facilities classified as RTC's.

Sources and Qualifications of the Data

The data presented in this report were collected in the Inventory of Mental Health Facilities, a mail survey conducted in January 1970 by the Biometry Branch of NIMH with the cooperation and assistance of the State mental health authorities.

In addition to RTC's, other types of facilities surveyed included public and private mental hospitals, general hospitals with separate psychiatric facilities, outpatient psychiatric clinics, mental health day/night facilities, community mental health centers, and other multi-service psychiatric facilities.

Since the Inventory is a general purpose form, which was sent to all types of facilities, some of the questions are not particularly relevant to RTC's. For example, responses to the Inventory show how many RTC's exclude suicidal children but provide no information on the number of RTC's which exclude brain damaged children, psychotic children, physically handicapped children, delinquents and others which are more appropriate classifications for children. Despite this fact, the report contains much informative data on RTC's, some of which is available on a national basis for the first time.

Whenever possible, data in this report have been adjusted to include estimates for RTC's which did not report certain information. The estimation procedures and an analysis of nonrespondents is given in Appendix II.

Ratios and averages presented in this report were derived from data which include estimates for the nonresponding RTC's. These terms and others such as those that relate to types of services are defined in Appendix I. Special symbols used in the tables are shown on page iv at the beginning of this report. Since many of these definitions and symbols have specialized meanings, familiarity with them will aid in the interpretation of the data.

Residential Treatment Centers and Other Psychiatric Facilities Serving Children

Residential treatment centers make a significant contribution in the provision of psychiatric care and treatment to children in the United States. During 1968, the latest year for which information was available from all types of facilities, RTC's cared for 16 percent of the estimated 91,000 psychiatric inpatients under 18 years of age (Table A). Only general hospitals with psychiatric services and public mental hospitals provided psychiatric inpatient care to more children during that year.

RTC's are primarily residential facilities, but they also provide a limited amount of outpatient care. This fact is reflected in Table A, which shows that RTC's served only four percent of the 686,000 children under care in all psychiatric facilities during 1968 in comparison with the 16 percent cared for in inpatient services only.

Unlike RTC's, few mental hospitals are operated primarily for children. Of the 462 public (excluding Federal) (310) and private mental hospitals (152) operating in the United States during 1969, only 15 or three percent were classified as psychiatric hospitals for children. These hospitals are closely akin to RTC's both in type of children cared for and in the services provided, but there are also some marked differences

TABLE A. ESTIMATED PROPORTIONS OF CHILDREN UNDER 18 YEARS OF AGE UNDER CARE IN PSYCHIATRIC FACILITIES: UNITED STATES, 1968

Types of Facilities	Types of Services	
	All Services	Inpatient Services Only
	Number of Children Under Care	
All Facilities, Total	686,000	91,000
	Percent Distribution of Children	
All Facilities, Total	100	100
Residential Treatment Centers	4	16
Outpatient Clinics	77	--
Community Mental Health Centers	7	8
General Hospitals	5	40
State and County Mental Hospitals	4	28
Mental Health Day/Night Units	2	--
Private Mental Hospitals	1	8

Source: Selected published and unpublished data from Biometry Branch, Office of Program Planning and Evaluation, NIMH.

between the two types of facilities. The 15 hospitals as a group, which were largely state-owned in contrast to private ownership patterns that predominated in the 261 RTC's, were generally larger, provided more research activities, had more professional staff in relation to the number of residents and expended more than twice as much money per patient day than RTC's. Comparisons between the two types of facilities are shown in Table B.

In addition to psychiatric hospitals for children, some mental hospitals which serve persons of all ages provide special services to children. During 1969 about half of the public mental hospitals reported having these services.

TABLE B. COMPARISONS OF SELECTED DATA ON PSYCHIATRIC HOSPITALS FOR CHILDREN AND RESIDENTIAL TREATMENT CENTERS: UNITED STATES, 1969 1/

Selected Measures for 1969	Residential Treatment Centers (N=261)	Psychiatric Hospitals for Children (N=15)
Predominant type of ownership	Private non-prof. (89 percent)	State and County (73 percent)
Predominant geographic division	East North Central (31 percent)	East North Central (53 percent)
Median size (in beds)	37	84
Annual number of patient days, all facilities	4,521,000	361,000
Average daily census per facility	47	66
Average daily percent occupancy per facility	81%	78%
Annual number of additions, all facilities	7,596	2,778
Annual additions per 1,000 U.S. resident population under 18 years 2/	10	4
Annual additions per 1,000 discharges	102	100
Proportion of facilities with research activities	9%	54%
Full-time equivalents per 1,000 residents 3/, 4/		
Professional employees	307	1,035
Non-professional employees	592	1,576
Annual total expenditures	$117,065,000	$24,552,000
Annual salary expenditures	$65,554,000	$18,193,000
Average total expenditures per patient day	$27	$66
Average salary expenditures per patient day	$15	$50

1/ Includes estimates for nonreporting RTC's and psychiatric hospitals (see Appendix II).

2/ The population used in the calculation of these rates was the civilian resident population under 18 years as of July 1, 1969. Source: Current Population Reports, Series P-25, No. 437, January 1970.

3/ Full-time equivalent is taken as a 40-hour work week.

4/ Patients resident in facilities on December 31, 1969.

CHARACTERISTICS OF RESIDENTIAL TREATMENT CENTERS

Number of Facilities and Beds

The 261 RTC's were similar as a group in terms of bed size, ownership, and geographic distribution. Most of the RTC's were small with nearly one-quarter maintaining less than 25 beds and approximately two-thirds less than 50 beds. Only 10 percent had 100 beds and over (Table C).

Eighty-nine percent of the RTC's were operated by church (18 percent) or other nonprofit (71 percent) groups. State or county governments owned only four percent of the RTC's (Table C), a sharp contrast to public ownership patterns that predominate in mental hospitals.

The RTC's were highly clustered with regard to geographic division. (The States that compose each of the nine Census Bureau geographic divisions are given in Appendix I.) Sixty percent of the RTC's and nearly two-thirds of the inpatient beds were concentrated in three geographic divisions—East North Central, Pacific, and Middle Atlantic (Table D). In sharp contrast, the South, which is comprised of the South Atlantic, East South Central, and West South Central Divisions, collectively maintained only 11 percent of the RTC's and 15 percent of the inpatient beds.

The South Atlantic and East South Central divisions also maintained the fewest beds per 100,000 persons under 18 years residing in their divisions, while the New England and Middle Atlantic divisions maintained the most RTC beds per 100,000 persons under 18 years of age (Table D).

As shown in Table 1, 11 States, which are concentrated for the most part in the South and in the Mountain States, had no residential treatment centers. In addition, 10 other States had only one RTC. On

TABLE C. NUMBER AND PERCENT DISTRIBUTION OF RESIDENTIAL TREATMENT CENTERS AND BEDS; AND MEDIAN NUMBER OF BEDS PER GROUP BY BED SIZE AND TYPE OF OWNERSHIP: UNITED STATES, 1969 1/

Bed Size and Type of Ownership	Residential Treatment Centers		Inpatient Beds 2/		
	Number	Percent	Number	Percent	Median Number Per Group
All RTC's	261	100.0	15,129	100.0	37
Bed Size					
15 beds and under	19	7.3	197	1.3	9
16-24 beds	43	16.5	882	5.8	21
25-34 beds	50	19.2	1,465	9.7	30
35-49 beds	57	21.8	2,315	15.3	40
50-74 beds	49	18.8	2,897	19.1	60
75-99 beds	16	6.1	1,337	8.8	84
100 beds and over	27	10.3	6,036	40.0	150
Ownership					
Nonprofit	232	89.2	13,553	89.6	36
Church	47	18.0	2,763	18.3	40
Other nonprofit	185	71.2	10,790	71.3	36
Proprietary	17	6.4	916	6.1	31
State and county government	11	4.4	660	4.4	49

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ Beds set up and staffed for use as of December 31, 1969.

TABLE D. NUMBER AND PERCENT DISTRIBUTION OF RESIDENTIAL TREATMENT CENTERS AND BEDS; MEDIAN NUMBER OF BEDS PER GROUP AND BEDS PER 100,000 RESIDENT POPULATION UNDER 18 YEARS BY GEOGRAPHIC DIVISION: UNITED STATES, 1969 1/

Geographic Division	Residential Treatment Centers 1/		Inpatient Beds 2/			Beds Per 100,000 U.S. Resident Population Under 18 3/
	Number	Percent	Number	Percent	Median Number Per Group	
United States	261	100.0	15,129	100.0	37	21
New England	36	13.8	1,539	10.2	33	39
Middle Atlantic	38	14.6	4,278	28.2	49	35
East North Central	80	30.7	3,942	26.1	40	28
West North Central	31	11.9	1,053	7.0	32	19
South Atlantic	14	5.4	809	5.3	33	7
East South Central	4	1.5	293	1.9	**	6
West South Central	10	3.8	1,188	7.9	60	17
Mountain	9	3.4	269	1.8	28	9
Pacific	39	14.9	1,758	11.6	36	19

1/ All data in this table include estimates for nonreporting RTC's with the exception of the distribution of residential treatment centers by division, which was 100 percent reported (see Appendix II).

2/ Beds set up and staffed for use as of December 31, 1969.

3/ The population used in the calculation of these rates was the civilian resident population of the United States under 18 years of age as of July 1, 1969. Source: Current Population Reports, Series P-25, No. 437, January 16, 1970.

the other hand, three States—Wisconsin, New York, and California—each had more than 20 RTC's.

As measured by the median number of inpatient beds, the RTC's tended to be larger in the West South Central and Middle Atlantic Divisions (Table D). The median, the number of beds equaled or exceeded by 50 percent of the RTC's within a division, is shown in place of the average (mean) since the median is not unduly influenced by RTC's with large numbers of beds which are concentrated in a few divisions.

Types of Services Provided

The types of services provided in RTC's have been classified into two categories as follows: (1) patient care services and (2) research, education, and training activities.

Patient care services include those such as "inpatient treatment" and "special education" which are provided to emotionally disturbed children in the course of their treatment. The extent to which RTC's provided these services are shown by State in Table 1 and by bed size and geographic division in Table 2.

Research, education, and training activities include supportive and evaluative activities not directly related to the care of individual children. The extent to which RTC's provided these services are shown by State in Table 3 and by bed size and geographic division in Table 4.

In addition to "inpatient treatment" which was provided by all RTC's, other patient care services frequently provided include "special education," "diagnostic service," and "aftercare" which were provided by 70 percent, 44 percent, and 34 percent of the RTC's respectively (Table 2).

The research, education, or training activity most frequently supplied was "in-service training to staff," which was provided in nearly two-thirds of the RTC's (Table 4). Other activities provided in a relatively large proportion of RTC's included "consultation to community agencies," and "general public education," which were provided in 24 percent and 22 percent of the RTC's respectively.

Restrictions Regarding Admission

On the NIMH Inventory, RTC's were asked specifically for age and diagnostic restrictions applied to persons seeking services. There are other restrictions such as those relating to "sex" but these were not specifically asked. However, data from a 1966 survey conducted by the Center for Urban Studies of the University of Chicago show that 54 percent of "institutions for emotionally disturbed children" accept both

TABLE E. MINIMUM AND MAXIMUM AGES MOST FREQUENTLY ACCEPTED FOR ADMISSION IN RESIDENTIAL TREATMENT CENTERS BY TYPE OF SERVICE: UNITED STATES, JANUARY 1970 1/

Type of Service	Number of RTC's Providing Services	Most Frequently Reported:	
		Minimum Age	Maximum Age
Inpatient Treatment	261	6	18
Special Education	183	6	18
Diagnostic Service	116	6	18
Aftercare	90	6	18
Halfway House	48	12	18
Outpatient Treatment	48	0	18
Day/Night Treatment	44	6	12

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

TABLE F. PERCENT OF RESIDENTIAL TREATMENT CENTERS SPECIFYING RESTRICTIONS WITH REGARD TO THE ADMISSION OF CERTAIN DIAGNOSTIC GROUPS BY BED SIZE: UNITED STATES, JANUARY 1970 1/

Bed Size	Number of RTC's	No Diagnostic Restrictions	Diagnostic Restrictions				
			Serves all but:				
			Alcoholics	Drug Abusers	Mental Retardates	Suicidal Patients	Others2/
		Percent of Residential Treatment Centers Specifying Restriction3/					
All Sizes	261	35	21	14	46	16	20
Less than 25 beds	62	41	12	7	29	7	8
25-49 beds	107	40	14	10	49	15	16
50-74 beds	49	21	34	21	64	19	31
75-99 beds	16	36	21	29	50	21	69
100 beds and over	27	27	31	27	42	35	19

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ Includes such categories as "psychotics," "brain damaged," "physically handicapped," and "delinquent."

3/ Because RTC's may specify more than one type of restriction, the rows of percents do not add to 100 percent.

males and females, 28 percent accept males only, and 18 percent accept females only.[3]

Thirty-five percent of the RTC's reported no geographic restrictions on admissions; 25 percent specified the acceptance of children residing within a certain State; 30 percent specified the acceptance of children residing in certain local areas within a State; and 10 percent said they accepted children whose family residence was in any of several States. However, for some RTC's it was not clear whether the information provided on "geographic restrictions" referred to actual policy or merely stated the family residence for most of the children under care.

The percent distribution of RTC's by minimum and maximum ages required for admission, and type of service is given in Table 5. For most services the age range most frequently specified was six to 18 years (Table E). Only 10 percent of the RTC's stated they will provide inpatient and special education services to persons over 18 years of age (Table 5). However, other services, especially those that usually follow inpatient treatment episodes were available in proportionately more RTC's to persons of older ages. Three such services and the accompanying proportions of RTC's specifying eligibility to persons over 18 years of age were: aftercare (55 percent); outpatient treatment (50 percent) and halfway house care (31 percent).

Thirty-five percent of the RTC's stated they had no diagnostic restrictions. Groups mentioned as being ineligible for service in the largest proportion of RTC's included mental retardates (46 percent), alcoholics (21 percent), and suicidal patients (16 percent).

The larger RTC's appeared to be more restrictive in the admission of certain diagnostic groups than the smaller ones. For example, only 27 percent of the RTC's with 100 beds and over stated they had no diagnostic restrictions as compared with 41 percent of the RTC's with less than 25 beds (Table F). Conversely, a larger proportion of RTC's in the two largest bed size groups (75–99 beds; 100 beds and over) than in the two smallest bed size groups (less than 25 beds; 25–49 beds) stated they would exclude patients in almost all of the diagnostic groups shown in Table F.

UTILIZATION OF RESIDENTIAL TREATMENT CENTERS

Patient Movement and Volume of Service

Patient movement and annual volume of service are shown by bed size and by geographic division in Table 6. An estimated 21,000 patients received over 4.5 million days of care in RTC's during 1969 (Table 6). Of these, more than 11,000 children or 54 percent were under care in RTC's in the East North Central (26 percent) and the Middle Atlantic Divisions (28 percent). The data in the latter group were unduly influenced by one facility which accounted for 21 percent of the patients under care in the Middle Atlantic Division. The fewest children were in the Mountain and East South Central Divisions, which jointly cared for less than 1,000 children (Table 6).

Utilization Indices

As a complement to data on absolute numbers of patients in RTC's given in the preceding section, indices which show the relative extent to which RTC's are utilized in different bed size groups and in different geographic divisions are of interest. These indices are shown in Table 7.

Although the average daily census per RTC which represents the average number of beds occupied daily by the residents was naturally higher in the larger RTC's, the percent occupancy was not. This latter measure, which is the ratio of the average daily census per RTC to the average number of beds per RTC expressed as a percent, shows on the average how close to capacity the RTC's operate daily. RTC's with 100 beds and over had an 80 percent occupancy rate while in contrast RTC's with 25–49 beds and 50–74 beds had occupancy rates of 86 percent and 85 percent respectively.

RTC's with 100 beds and over surpassed all other size groups in additions, average resident patients, and days of care respectively per 100,000 U.S. civilian resident population under 18 years (Table 7). However, the turnover rate as measured by the number of additions per 100 beds and per 100 average residents respectively was highest in RTC's with less than 25 beds. In general, both these measures, with the exception of an upturn in the 75–99 bed size group, varied inversely with bed size group.

As measured by the number of additions, average resident patients, and number of days of care respectively per 100,000 persons under 18 years of age residing in a division, the New England States had the highest rate of utilization and the South Atlantic States the lowest.

In all geographic divisions with the exception of the South Atlantic, the number of patients added during 1969 exceeded those discontinued. The excess of discontinuations over additions in the South Atlantic division was largely attributed to one RTC.

CHARACTERISTICS OF STAFF EMPLOYED

Distribution of Employees and Manhours Worked

The distribution of the number of employees and manhours worked and the average number of manhours worked in a week per employee are shown by staff discipline in Table 8. RTC's employed nearly 15,000 persons who collectively worked approximately 487,000 manhours per week or an average of 33 hours per person.

Most of the persons were employed 35 or more hours weekly (full-time). The 10,400 employees who worked full-time amassed 421,000 manhours, and accounted for 71 percent and 86 percent of all employees and all weekly manhours respectively. The average number of hours worked weekly ranged from 10 hours for psychiatrists to 37 hours for semi-professional and nonprofessional health workers.

Table 9 shows the extent to which "professional" persons are employed in residential treatment centers. These employees comprised 40 percent of the work force in RTC's, but provided only 34 percent of the manhours in a week, a reflection of the large proportions of professional employees working part-time or as trainees. Over one-half of the part-time employees and nearly three-quarters of the trainees were professional employees. Professional employees worked an average of 28 hours a week or on the average eight hours a week less than other employees.

For comparative purposes, professional employees and manhours worked in a week as percent of all employees and manhours, and average weekly hours worked by professional staff are shown for residential treatment centers and other psychiatric inpatient facilities in Table G.

Staffing Patterns for Selected Professional Staff Disciplines

Tables 10 through 14 and Table H present detailed data on number of employees and hours worked in RTC's by persons in selected professional staff disciplines. Tables 10 through 12 and Table H present staffing patterns by bed size group; tables 13 and 14 present staffing patterns by geographic division.

Based on the broad occupational groupings on the 1969 NIMH Inventory, detailed data are shown for six professional staff disciplines, as follows: (1) psychiatrists, (2) psychologists; (3) social workers; (4) registered nurses; (5) schoolteachers; and (6) counselors and therapists, which includes vocational rehabilita-

TABLE G. PROFESSIONAL EMPLOYEES AND MANHOURS AS PERCENT OF TOTAL EMPLOYEES AND MANHOURS, AND AVERAGE MANHOURS WORKED IN WEEK BY PROFESSIONALS IN RESIDENTIAL TREATMENT CENTERS AND IN OTHER PSYCHIATRIC INPATIENT FACILITIES: UNITED STATES, JANUARY 1970 1/

Type of Facility	Employees		Manhours		Average Hours Worked in Week Per "Professional"
	Total Number	Percent "Professional"	Total Number	Percent Worked by "Professionals"	
Residential Treatment Centers	15,000	40	487,000	34	28
State and County Mental Hospitals 2/	225,000	19	8,843,000	18	38
Private Mental Hospitals 2/	25,000	31	854,000	28	31
General Hospitals with Separate Psychiatric Inpatient Units 3/	34,000	48	1,107,000	45	31

1/ This table includes estimates for nonreporting facilities (see Appendix II).

2/ Includes psychiatric hospitals for children.

3/ Includes only employees and hours worked in separate psychiatric inpatient units of the hospitals.

tion counselors, occupational therapists, recreational therapists and assistants to all three. Jointly these disciplines accounted for nearly 84 percent of all professionals employed in RTC's.

Information on the level of training for staff personnel was not collected in great detail in this survey. For this reason, information on level of training as of January 1968, which was collected in greater detail in an earlier survey and published in a special report of staffing patterns in all types of mental health facilities[6] is presented when applicable to supplement some of the data shown in this report.*

Psychiatrists. There were 466 psychiatrists employed in RTC's (Table H) and over 88 percent of RTC's had at least one psychiatrist (Table 10). Most psychiatrists were employed on a part-time basis. Only five percent of the RTC's employed at least one full-time psychiatrist (Table 10) and less than eight percent of all psychiatrists in RTC's were employed full-time (Table 11).

In comparison with other professional disciplines employed by RTC's, a greater proportion of psychiatrists (over 12 percent) were employed as trainees.

No data on level of training of psychiatrists are available for 1969. Data as of January 1968, however, show that nearly three-fifths were board certified.[6] The proportion of psychiatrists employed in other psychiatric facilities as of January 1968, who were board certified, ranged from 24 percent in State mental hospitals to over 40 percent in both private mental hospitals and general hospitals with separate inpatient psychiatric units.

Psychologists. Staffing patterns of psychologists were similar to those of psychiatrists in that the majority were employed part-time and the number of trainees in comparison with the total staff was relatively large. At least one psychologist was employed in two-thirds of the RTC's, but only 26 percent of the RTC's had one or more psychologists who worked full-time (Table 10) and only 36 percent of the 398 psychologists were employed full-time (Table 11). Nearly 11

TABLE H. NUMBER OF EMPLOYEES AND AVERAGE NUMBER OF MANHOURS WORKED PER EMPLOYEE IN A WEEK 1/ IN RESIDENTIAL TREATMENT CENTERS BY BED SIZE AND SELECTED STAFF DISCIPLINES: UNITED STATES, JANUARY 1970 2/

Selected Professional Staff Disciplines	Beds Size Group					
	All Sizes	Less than 25 Beds	25-49 Beds	50-74 Beds	75-99 Beds	100 beds and over
	Number of Employees 3/					
Psychiatrists	466	83	191	77	22	93
Psychologists	398	67	125	85	23	98
Social Workers	1,630	212	616	451	66	285
Registered Nurses 4/	203	18	74	45	6	60
Schoolteachers - BA and above	1,542	150	365	306	170	551
Counselors and therapists and their assistants 5/	678	51	146	69	36	376
	Average Number of Manhours Worked in Week per Employee 3/					
Psychiatrists	10.2	12.2	7.5	12.2	8.4	12.6
Psychologists	22.3	21.2	19.5	23.9	14.5	27.1
Social Workers	32.0	31.2	32.4	31.2	32.3	33.0
Registered Nurses 4/	29.5	28.3	23.9	31.6	29.2	35.2
Schoolteachers - BA and above	32.3	29.5	34.2	32.0	30.0	32.7
Counselors and therapists and their assistants 5/	28.9	23.5	27.9	24.2	20.0	31.7

1/ The week for which staff data were requested in the survey was January 11-17, 1970.

2/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

3/ Includes full-time employees, part-time employees, and trainees.

4/ Includes student nurses.

5/ Includes vocational rehabilitation counselors, occupational therapists, recreational therapists and assistants to all three.

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* It should be noted that the January 1968 data are based on information collected in an incomplete universe of RTC's since only 143 RTC's are included. However, since the distribution of these facilities by bed size differed little from the distribution of the 261 RTC's by bed size in 1969, it is likely that the level of training for specific professional disciplines would also be distributed similarly.

percent of the psychologists were trainees, a proportion exceeded only by psychiatrists.

The majority of the psychologists had M.A. degrees or higher; eighty-four percent of the full-time psychologists, 92 percent of the part-time, and 79 percent of the trainees.

No data are available on the proportion of psychologists employed in 1969 who had Ph.D.'s. However, data for January 1968 show that nearly 46 percent of psychologists employed in RTC's had the doctorate.[6] This compares with 40 percent, 58 percent and 69 percent of all employed psychologists who had Ph.D.'s in State and county mental hospitals, general hospitals with separate psychiatric units, and private mental hospitals respectively.

Social Workers. Social workers along with schoolteachers were employed more universally in residential treatment centers than other types of professional employees. Not only were more social workers employed in RTC's, but also more RTC's (97 percent) had at least one social worker on their staff (Table 10). Over two-thirds of the social workers were employed 35 or more hours in a week. Among the professional staff this proportion was exceeded only by schoolteachers (72 percent).

The proportion of social workers in 1969 who had M.A. degrees or higher was 79 percent for full-time social workers, 84 percent for part-time, and 40 percent for trainees.

A Master of Social Work is the most frequently earned advanced degree in the social work field since few social workers earn a Ph.D.

In January 1968, only 1.3 percent of the social workers had either a Ph.D. degree or advanced third year training. For other types of inpatient mental health facilities (e.g. mental hospitals) the proportion of social workers with this level of advanced training ranged from less than one percent in State and county mental hospitals to three percent in private mental hospitals.[6]

Registered Nurses. Of the six professional occupational groups under study, fewer registered nurses (203) were employed in RTC's than any other group. Less than 43 percent of the RTC's employed a registered nurse on either a full- or part-time basis (Table 10). However, over three-fifths of those employed as R.N.'s worked full-time (Table 11).

Schoolteachers. Next to social workers, schoolteachers were utilized to a greater extent in residential treatment centers than any other type of professional employee. This is not surprising since RTC's serve primarily children of school age.

RTC's employed 1,542 schoolteachers which may be an underestimate since only teachers with B.A. degrees or higher are included. Over four-fifths of the RTC's employed one or more teachers on a full-time basis and nearly 72 percent of all schoolteachers worked full-time, a proportion which exceeds that for any of the other five professional disciplines under study in this section. In contrast, less than six percent were employed as trainees, the lowest proportion for any of the professional disciplines.

Counselors, therapists and their assistants. This category is composed of vocational rehabilitation counselors and assistants, occupational therapists and assistants, and recreational therapists and assistants. Of the three components of this category, recreational therapists accounted for more than twice the number of persons represented in each of the other two components (Table 8).

Less than one-half the RTC's had one or more counselors or therapists on their staff (Table 10). Of the other five professional groups, only registered nurses were employed in fewer RTC's. Slightly over one-half of those employed in this staff discipline had full-time jobs.

Staff Utilization

In evaluating the utilization of staff in residential treatment centers, it is important to know not only the number of employees and manhours worked, but also measures of utilization which reflect the relative number of hours worked by each selected professional discipline.

Three such measures are: (1) the average number of manhours worked in a week per employee, which is shown by bed size class in Table H and by geographic division in Table 13; (2) the number of full-time equivalents (FTE's) which is shown by bed size class in Table 12 and by geographic division in Table 14; and (3) the number of full-time equivalents per 1,000 RTC residents which is also shown by bed size class and by geographic division in Tables 12 and 14 respectively.

Although each of the above terms is defined in Appendix I, some further clarification is needed on the meaning of full-time equivalent (FTE) and full-time equivalents per 1,000 residents. Full-time equivalent is a hypothetical measure which is obtained by dividing the total manhours worked by all employees in a particular discipline by 40 hours to indicate the number of persons working a forty-hour week that would be required to provide this many manhours. Thus FTE's can be used to provide comparability between staff discipline based on total hours worked.

The number of FTE's per 1,000 residents is calculated by dividing the number of FTE's by the number of persons resident in residential treatment centers as of December 31, 1969. Patients resident at the end of 1969 are used rather than the average residents during the year because the end of 1969 is closer in time to January 11–17, 1970, the week for which staff data were reported.

This index is an overstatement of time devoted directly to the care of residents because it reflects, in addition to hours spent in direct contact with the patient, hours spent in meetings, administrative work and other activities in which the patient is not involved. Furthermore, it should be noted that time spent in nonpatient activities varies by discipline. For example, registered nurses in all likelihood spend more time in providing direct care to patients than psychiatrists, who are often called upon to provide consultative services to other staff members. These points should be kept in mind when comparisons are made between staff disciplines.

As measured by the number of FTE's per 1,000 residents, social workers were utilized to a greater extent than any other professional discipline for all RTC's combined (Table 12). Apropos of this, it is interesting to note that the utilization of social workers was proportionately greatest in RTC's of less than 75 beds and in these bed size groups social workers had more FTE's per 1,000 residents than any other professional discipline (Table 12).

However, in residential treatment centers of 75 beds and over and particularly in those with 100 beds and over, the use of schoolteachers predominated. This finding coupled with the disproportionately large utilization of occupational therapists, recreational therapists and other educational and training specialists in the largest residential treatment centers suggest the hypothesis that education and training are stressed in the largest facilities.

On the other hand, psychiatrists, as measured by the number of FTE's per 1,000 residents, were utilized to a far greater extent in the smallest RTC's. In general, with only one exception, as the bed size increases, the number of "psychiatrist" FTE's per 1,000 residents decreases (Table 12). This finding may indicate that the smallest residential treatment centers emphasize psychiatric treatment including psychotherapy to a greater extent than the larger ones.

EXPENDITURES

Expenditures in residential treatment centers are shown by bed size (Table 15) and by geographic division (Table 16). The total expenditures in these tables have been classified into more specific sub-categories as follows:

(1) *Salaries* of personnel.

(2) *Other operating expenses* exclusive of salaries which include maintenance and ordinary repair costs and other amounts expended in the day to day operation of the RTC's.

(3) *Capital expenditures*, which include costs of construction of buildings, additions, and purchases of durable equipment, and other expenses that are largely non-recurring.

RTC's spent over 121 million dollars during 1969 with 56 percent of this amount allocated to employee salaries (Tables 15 and 16). Other types of inpatient psychiatric facilities and the proportion of total expenditures allocated to salaries during 1969 were psychiatric hospitals for children (76 percent), State and county mental hospitals (75 percent), and private mental hospitals (61 percent).

Capital expenditures in RTC's amounted to 12 percent of total expenditures. Approximately 32 percent of the RTC's reported no capital expenditures during 1969.

The average total expenditures per patient day, which is the average amount spent to care for one inpatient for one day in RTC's during 1969 was $27 (Table J); the average salary expenditures per patient day was $15. In comparison with RTC's, expenditures per patient day were much less in public mental hospitals ($14 total; $10 salaries) and much greater in private mental hospitals ($49 total; $30 salaries) and in psychiatric hospitals for children ($66 total; $50 salaries).

The reader is cautioned that the average expenditures shown in Table J are probably overstated since the numerator reflects expenditures for services provided in inpatient and in other services, while the denominator reflects the days provided in inpatient service only. However, the expenditures in other services in RTC's are small relative to the expenditures made in the provision of inpatient care. For this reason, the average expenditures, although somewhat overstated, give a good indication of the average amounts expended to provide one day of inpatient care to one patient.

The average expenditures per patient day varied somewhat according to bed size (Table J). In general, the average expenditures were lowest in the RTC's with 75 beds and over and considerably higher in RTC's with less than 75 beds.

Some clues to reasons for larger average expenditures, especially salary expenditures, per patient day, in smaller RTC's can be gleaned from an examination of staffing patterns among professionals. This task is made difficult in that salary expenditures are not available by staff discipline. In addition, there are undoubtedly differences in salary scales for the same occupational groups between RTC's of differing sizes, in different geographic locations, and providing widely divergent services.

Since professional employees as a group are paid on the average more than nonprofessional employees, RTC's with more professional full-time equivalents per 1,000 residents (see discussion on page 12) would be expected to have higher average salary expenditures per patient day. This is indeed the case as is shown in Table K, which compares measures of staff utilization and average salary expenditures in RTC's by bed size.

The total expenditures per patient day ranged from 11 dollars in the West South Central Division to 37 dollars in the New England Division (Table J).

It should be recognized that due to the relatively small number of RTC's in certain geographic divisions, the disproportionately large expenditures of a single RTC have dramatically raised the averages in some divisions. This is especially true of large capital expenditures by RTC's that have helped to raise the average for total expeditures in some divisions. The average capital expenditures per patient day in a division can be calculated by subtracting the average operating expenditures from the average total expenditures.

TABLE J. AVERAGE EXPENDITURES PER PATIENT DAY IN RESIDENTIAL TREATMENT CENTERS BY BED SIZE AND GEOGRAPHIC DIVISION: UNITED STATES, 1969 1/

Bed Size and Geographic Division	Type of Expenditures 2/			
	Total Expenditures 2/,3/	Operating Expenditures 2/		
		Total	Salaries	Other Operating
	Average Expenditures per Patient Day			
All RTC's	$27	$24	$15	$9
Bed Size				
Less than 25 beds	36	32	21	11
25-49 beds	29	26	17	9
50-74 beds	31	29	19	10
75-99 beds	19	17	10	7
100 beds and over	23	19	12	7
Geographic Division				
New England	37	31	21	10
Middle Atlantic	27	26	15	11
East North Central	26	23	15	8
West North Central	25	24	15	9
South Atlantic	34	20	14	6
East South Central	**	**	**	**
West South Central	11	10	6	4
Mountain	19	18	12	6
Pacific	28	24	16	8

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ For inclusions under each type of expenditure, see Section VI.

3/ Includes capital expenditures which are not shown separately.

TABLE K. COMPARISONS OF SELECTED MEASURES OF STAFFING PATTERNS AND AVERAGE SALARY EXPENDITURES PER PATIENT DAY BY BED SIZE: UNITED STATES, 1969

Bed Size	Employees		Full-time Equivalents Per 1,000 Residents 2/,3/		Average Salary Expenditures Per Patient Day
	Total Number	Percent Professional	Professionals	Non-Professionals	
All Sizes	13,019	39.8	307	596	$15
Less than 25 beds	1,365	48.4	529	723	$21
25-49 beds	3,843	39.6	346	722	$17
50-74 beds	3,012	34.4	332	766	$19
75-99 beds	765	44.6	245	375	$10
100 beds and over	4,034	40.1	245	462	$12

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ Full-time equivalent is taken as a 40-hour work week.

3/ Patients resident in RTC's on December 31, 1969.

SUMMARY

The 261 facilities classified as RTC's in 1969 were highly clustered in terms of bed size, ownership, and geographic distribution. The majority were small, privately owned institutions concentrated in three geographic divisions—the East North Central, Pacific, and Middle Atlantic—which jointly maintained 60 percent of the facilities and nearly 70 percent of the beds.

Over two-thirds of the RTC's provided special education services. With less frequency many also provided diagnostic (44 percent) and aftercare services (34 percent).

There was some variation in the age groups served according to type of service. More facilities accepted younger children for inpatient service than for halfway house care, aftercare, and outpatient treatment, three services which frequently follow episodes of inpatient care.

Over one-third of the facilities reported no diagnostic restrictions regarding admission. Of those reporting restrictions, the group most frequently mentioned as being ineligible for service was mental retardates.

Nearly 21,000 patients were under care in RTC's during 1969. There were 102 persons added for each 100 discontinued and on the average 80 percent of the beds were occupied daily. The rate of turnover, measured by the number of additions per 100 beds, was lowest in the largest RTC's and in general varied inversely with bed size class.

Of the 15,000 persons employed in RTC's, approximately 40 percent were professional employees, most of whom were employed part-time. Social workers and schoolteachers, as measured by both the number of employees and manhours worked, were utilized in RTC's to a greater extent than any of the other professions.

The average total expenditures and average salary expenditures per patient day were 27 dollars and 15 dollars respectively. The average expenditures per patient day tended to be higher in RTC's with less than 75 beds. This was due in part to the greater utilization of professional employees including psychiatrists in the smaller RTC's.

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DETAILED TABLES

TABLE 1—Number of Residential Treatment Centers Providing Specified Patient Care Services: United States and Each State, January 1970

TABLE 2—Percent of Residential Treatment Centers Providing Specified Direct Patient Services by Bed Size and Geographic Division: United States, January 1970

TABLE 3—Number of Residential Treatment Centers Providing Specific Research, Education, and Training Activities: United States and Each State, January 1970

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TABLE 5—Percent Distribution of Residential Treatment Centers According to Minimum Age and Maximum Age Required For Admission by Type of Service: United States, January 1970

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TABLE 13—Number of Employees and Average Number of Manhours Worked per Employee in a Week in Residential Treatment Centers by Geographic Division and Selected Professional Staff Disciplines: United States, January 1970

TABLE 14—Number of Manhours Worked in a Week, Number of Full-Time Equivalents and Number of Full-Time Equivalents per 1,000 Residents in Residential Treatment Centers by Geographic Division and Selected Professional Staff Disciplines: United States, January 1970

TABLE 15—Number and Percent Distribution of Expenditures in Residential Treatment Centers by Type of Expenditure and Bed Size: United States, 1969

TABLE 16—Number and Percent Distribution of Expenditures in Residential Treatment Centers by Type of Expenditure and Geographic Division: United States, 1969

TABLE 1. NUMBER OF RESIDENTIAL TREATMENT CENTERS PROVIDING SPECIFIED PATIENT CARE SERVICES: UNITED STATES AND EACH STATE, JANUARY 1970

(Definitions of terms are given in Appendix I)

State	Residential Treatment Centers		Type of Patient Care Service								
	Total No. Surveyed	Number 1/ Responding	Inpatient Treatmt.	Special Educa.	Diag-nostic	After-care	Half-way house	Outpt. Treatmt.	Day/Night Treatmt. 2/	Day Train'g	Vocational Rehabilitation
			Number of RTC's Providing Specified Patient Care Service								
United States	261	250	250	175	111	86	46	46	42	35	23
Alabama	-	-	-	-	-	-	-	-	-	-	-
Alaska	1	1	1	1	-	-	-	-	-	-	-
Arizona	-	-	-	-	-	-	-	-	-	-	-
Arkansas	-	-	-	-	-	-	-	-	-	-	-
California	25	24	24	16	11	13	6	3	6	2	1
Colorado	5	5	5	5	-	1	-	-	-	-	-
Connecticut	7	7	7	6	4	2	3	2	2	1	1
Delaware	1	-	-	-	-	-	-	-	-	-	-
District of Columbia	1	1	1	1	1	1	-	-	-	-	-
Florida	1	1	1	1	1	-	1	-	1	1	1
Georgia	2	2	2	1	-	1	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	-	-	-	-
Idaho	2	2	2	-	1	-	-	-	-	-	-
Illinois	14	14	14	9	2	2	3	1	-	-	-
Indiana	6	6	6	1	2	-	2	2	-	-	-
Iowa	4	3	3	3	3	1	-	3	1	-	-
Kansas	2	2	2	1	-	-	1	-	-	-	-
Kentucky	3	2	2	2	-	-	-	-	-	-	-
Louisiana	-	-	-	-	-	-	-	-	-	-	-
Maine	3	2	2	2	-	1	-	-	-	-	-
Maryland	6	6	6	5	4	3	-	1	3	2	2
Massachusetts	18	16	16	12	10	6	2	4	5	5	2
Michigan	18	18	18	10	9	8	1	1	-	4	2
Minnesota	9	9	9	6	3	3	1	-	1	-	-
Mississippi	-	-	-	-	-	-	-	-	-	-	-
Missouri	11	10	10	8	6	5	1	3	5	3	-
Montana	-	-	-	-	-	-	-	-	-	-	-
Nebraska	2	2	2	1	-	1	2	2	1	2	1
Nevada	-	-	-	-	-	-	-	-	-	-	-
New Hampshire	3	3	3	3	1	1	1	-	-	-	-
New Jersey	6	6	6	5	1	1	-	1	-	-	-
New Mexico	-	-	-	-	-	-	-	-	-	-	-
New York	22	22	22	13	15	11	8	6	3	3	3
North Carolina	2	2	2	2	1	1	-	-	-	-	-
North Dakota	1	1	1	1	1	-	-	-	-	-	1
Ohio	16	14	14	11	6	4	5	3	3	5	3
Oklahoma	2	2	2	1	1	-	1	-	-	-	1
Oregon	5	5	5	5	3	3	1	-	-	-	-
Pennsylvania	10	10	10	8	8	3	1	2	2	1	2
Rhode Island	4	4	4	2	-	-	1	1	-	1	-
South Carolina	-	-	-	-	-	-	-	-	-	-	-
South Dakota	2	2	2	2	2	-	-	-	-	-	-
Tennessee	1	1	1	1	-	1	-	1	1	-	-
Texas	8	7	7	4	1	-	-	-	2	-	1
Utah	1	1	1	1	1	1	-	1	1	1	-
Vermont	1	1	1	1	1	-	-	-	1	-	-
Virginia	1	1	1	1	1	1	-	1	1	1	-
Washington	8	8	8	5	4	4	2	4	2	-	1
West Virginia	-	-	-	-	-	0	-	-	-	-	-
Wisconsin	26	26	26	18	7	9	4	4	1	3	1
Wyoming	1	1	1	-	-	-	1	-	-	-	-

1/ Of the 261 facilities classified as residential treatment centers, 250 reported data on types of services provided by State.

2/ Only one RTC provided night treatment service. This same facility provided day treatment service & is counted only once.

TABLE 2. PERCENT OF RESIDENTIAL TREATMENT CENTERS PROVIDING SPECIFIED DIRECT PATIENT CARE SERVICES BY BEDSIZE AND GEOGRAPHIC DIVISION: UNITED STATES, JANUARY 1970[1]

(Definitions of terms are given in Appendix I)

Bed Size and Geographic Division	Number of RTC's	Type of Patient Care Service								
		Inpatient Treatmt.	Special Educa.	Diag-nostic	After-care	Half-way house	Outpt. Treatmt.	Day/Night Treatmt.	Day Train'g.	Vocational Rehab.
		Percent of RTC's Providing Specified Patient Care Service[2]								
All RTC's	261	100	70	44	34	18	18	17	14	9
Bed Size										
Less than 25 beds	62	100	64	47	36	9	17	20	15	7
25-49 beds	107	100	69	42	39	17	20	14	11	4
50-74 beds	49	100	77	32	34	30	21	19	11	9
75-99 beds	16	100	87	40	13	40	7	40	27	33
100 beds and over	27	100	65	73	27	15	15	4	23	23
Geographic Division										
New England	36	100	79	49	30	21	21	30	21	9
Middle Atlantic	38	100	68	63	40	18	24	13	11	13
East North Central	80	100	63	33	27	19	14	5	15	8
West North Central	31	100	76	52	35	17	28	28	17	7
South Atlantic	14	100	85	62	54	8	15	39	31	23
East South Central	4	100	**	**	**	**	**	**	**	**
West South Central	10	100	56	22	-	11	-	22	-	22
Mountain	9	100	67	22	22	11	11	11	11	-
Pacific	39	100	71	47	53	24	18	21	5	5

[1] This table includes estimates for nonreporting residential treatment centers (see Appendix II).

[2] Because RTC's may provide more than one type of service, the rows of percents do not add to 100 percent.

TABLE 3. NUMBER OF RESIDENTIAL TREATMENT CENTERS PROVIDING SPECIFIC RESEARCH, EDUCATION, AND TRAINING ACTIVITIES: UNITED STATES AND EACH STATE, JANUARY 1970
(Definitions of terms are given in Appendix I)

State	Residential Treatmt. Centers		Type of Research, Education, or Training Activity					
	Total No. Surveyed	Number Reporting 1/	In-Service Train'g to Staff	Consul.to Community Agencies	General Public Education	In-Service Train'g to Community Agencies	Research	Program Evaluation
			Number of RTC's Providing Specified Activity					
United States	261	250	161	59	55	35	23	22
Alabama	-	-	-	-	-	-	-	-
Alaska	1	1	1	1	-	-	-	-
Arizona	-	-	-	-	-	-	-	-
Arkansas	-	-	-	-	-	-	-	-
California	25	24	15	5	5	5	2	2
Colorado	5	5	4	1	-	-	-	-
Connecticut	7	7	4	2	2	2	-	-
Delaware	1	-	-	-	-	-	-	-
District of Columbia	1	1	1	-	1	-	-	-
Florida	1	1	1	1	-	1	-	-
Georgia	2	2	1	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	-
Idaho	2	2	-	-	-	-	-	-
Illinois	14	14	8	-	-	-	1	-
Indiana	6	6	4	1	-	1	-	1
Iowa	4	3	3	3	3	1	-	-
Kansas	2	2	2	-	-	1	1	-
Kentucky	3	2	-	-	-	-	-	-
Louisiana	-	-	-	-	-	-	-	-
Maine	3	2	-	1	-	-	-	-
Maryland	6	6	5	-	-	2	-	-
Massachusetts	18	16	13	6	7	1	3	3
Michigan	18	12	9	5	4	1	1	3
Minnesota	9	18	6	2	2	-	1	2
Mississippi	-	-	-	-	-	-	-	-
Missouri	11	10	8	3	4	2	2	1
Montana	-	-	-	-	-	-	-	-
Nebraska	2	2	1	1	-	-	-	-
Nevada	-	-	-	-	-	-	-	-
New Hampshire	3	3	1	1	1	1	1	-
New Jersey	6	6	2	2	-	-	1	1
New Mexico	-	-	-	-	-	-	-	-
New York	22	22	14	4	2	3	1	1
North Carolina	2	2	2	1	2	1	1	-
North Dakota	1	1	1	-	1	-	-	-
Ohio	16	14	12	6	4	2	2	1
Oklahoma	2	2	1	1	-	-	-	1
Oregon	5	5	3	2	4	2	-	1
Pennsylvania	10	10	6	3	3	1	2	1
Rhode Island	4	1	1	1	-	1	-	-
South Carolina	-	-	-	-	-	-	-	-
South Dakota	2	2	1	-	-	-	-	1
Tennessee	1	1	1	1	1	1	1	-
Texas	8	7	4	1	1	1	-	-
Utah	1	1	1	1	1	1	1	1
Vermont	1	1	1	-	-	-	-	-
Virginia	1	1	1	-	-	1	1	-
Washington	8	8	5	1	3	-	1	1
West Virginia	-	-	-	-	-	-	-	-
Wisconsin	26	26	18	2	4	3	-	1
Wyoming	1	1	-	-	-	-	-	-

1/ Of the 261 facilities classified as residential treatment centers, 250 reported data on types of research, education or training activities provided.

TABLE 4. PERCENT OF RESIDENTIAL TREATMENT CENTERS PROVIDING SPECIFIED RESEARCH, EDUCATION, AND TRAINING ACTIVITIES BY BEDSIZE AND GEOGRAPHIC DIVISION: UNITED STATES, JANUARY 1970[1]
(Definitions of terms are given in Appendix I)

Bed Size and Geographic Division	Number of RTC's	Type of Research, Education or Training Activity					
		In-Service Train'g to Staff of RTC's	Consul. to Community Agencies	General Public Education	In-Service Train'g to Community Agencies	Research	Program Evaluation
		Percent of RTC's Providing Specified Activity[2]					
All RTC's	261	64	24	22	14	9	9
Bed Size							
Less than 25 beds	62	54	36	25	20	10	9
25-49 beds	107	69	20	28	15	7	8
50-74 beds	49	66	19	13	6	9	9
75-99 beds	16	60	13	-	-	-	13
100 beds and over	27	69	23	19	19	23	12
Geographic Division							
New England	36	61	33	30	15	12	9
Middle Atlantic	38	58	24	13	11	11	8
East North Central	80	65	18	15	9	5	8
West North Central	31	76	31	35	14	14	14
South Atlantic	14	85	15	23	39	15	-
East South Central	4	**	**	**	**	**	**
West South Central	10	56	22	11	11	-	11
Mountain	9	56	22	11	11	11	11
Pacific	39	63	24	32	18	8	11

[1] This table includes estimates for nonreporting residential treatment centers (see Appendix II).

[2] Because RTC's may provide more than one type of service, the rows of percents do not add to 100 percent.

TABLE 5. PERCENT DISTRIBUTION OF RESIDENTIAL TREATMENT CENTERS ACCORDING TO MINIMUM AGE AND MAXIMUM AGE REQUIRED FOR ADMISSION BY TYPE OF SERVICE: UNITED STATES, JANUARY 1970[1]

(Definitions of terms are given in Appendix I)

Minimum Age and Type of Service	Percent Distribution of RTC's by Minimum Age	Maximum Age Specified for Admission				
		Total	7-12 Years	13-17 Years	18 Years	19-21+ Years 2/
		Percent Distribution of RTC's by Maximum Age				
Inpatient Treatment						
All minimum ages	100.0	100.0	14.8	41.2	34.0	10.0
0-5 years 2/	14.8	100.0	29.7	37.9	27.0	5.4
6 years	32.0	100.0	27.5	42.5	26.2	3.8
7-11 years	27.6	100.0	5.8	53.6	29.0	11.6
12-16+ years	25.6	100.0	-	28.1	53.1	18.8
Special Education						
All minimum ages	100.0	100.0	16.6	46.8	26.9	9.7
0-5 years 2/	13.7	100.0	33.3	37.6	20.8	8.3
6 years	33.1	100.0	31.0	48.3	19.0	1.7
7-11 years	27.5	100.0	6.2	60.5	22.9	10.4
12-16+ years	25.7	100.0	-	35.6	44.4	20.0
Diagnostic Service						
All minimum ages	100.0	100.0	17.1	42.4	30.6	9.9
0-5 years 2/	17.1	100.0	26.3	21.1	26.3	26.3
6 years	36.1	100.0	30.0	40.0	25.0	5.0
7-11 years	20.7	100.0	8.7	60.9	26.1	4.3
12-16+ years	26.1	100.0	-	44.8	44.8	10.4
Aftercare						
All minimum ages	100.0	100.0	7.0	22.1	33.7	37.2
0-5 years 2/	19.8	100.0	23.5	29.4	5.9	41.2
6 years	26.8	100.0	4.3	39.1	43.6	13.0
7-11 years	17.4	100.0	6.7	20.0	40.0	33.3
12-16+ years	36.0	100.0	-	6.5	38.7	54.8
Halfway House						
All minimum ages	100.0	100.0	2.2	19.6	52.1	26.1
0-5 years 2/	6.5	100.0	33.3	-	66.7	-
6 years	15.2	100.0	-	42.9	42.9	14.2
7-11 years	21.7	100.0	-	20.0	50.0	30.0
12-16+ years	56.6	100.0	-	15.4	53.8	30.8
Outpatient Treatment						
All minimum ages	100.0	100.0	8.7	23.9	34.8	32.6
0-5 years 2/	54.4	100.0	12.0	24.0	20.0	44.0
6 years	19.6	100.0	11.2	44.4	44.4	-
7-11 years	13.0	100.0	-	16.7	66.6	16.7
12-16+ years	13.0	100.0	-	-	50.0	50.0
Day/Night Treatment						
All minimum ages	100.0	100.0	40.5	38.1	14.3	7.1
0-5 years 2/	28.6	100.0	41.7	41.7	16.6	-
6 years	45.2	100.0	57.9	36.8	-	5.3
7-11 years	16.7	100.0	14.2	28.6	28.6	28.6
12-16+ years	9.5	100.0	-	50.0	50.0	-

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ Includes residential treatment centers that said they would accept persons of "all ages."

TABLE 6. PATIENT MOVEMENT AND ANNUAL VOLUME OF SERVICES IN INPATIENT SERVICE OF RESIDENTIAL TREATMENT CENTERS BY BEDSIZE AND GEOGRAPHIC DIVISION: UNITED STATES, 1969 1/

(Definitions of terms are given in Appendix I)

Bed Size and Geographic Division	Patient Movement During Year				Annual Volume of Service		
	Residents at Beginning of Year	Additions During Year	Discontinuations During Year 2/	Residents at End of Year	Patients Under Care	Average Resident Patients	Number of Days of Care
All RTC's	13,305	7,596	7,412	13,489	20,901	13,397	4,521,363
Bed Size							
Under 25 beds	895	764	741	918	1,659	906	314,162
25-49 beds	3,334	2,200	2,147	3,387	5,534	3,361	1,176,424
50-74 beds	2,524	1,577	1,541	2,560	4,101	2,542	886,755
75-99 beds	1,086	732	737	1,081	1,818	1,084	377,103
100 beds and over	5,466	2,323	2,246	5,543	7,789	5,504	1,766,918
Geographic Division							
New England	1,297	651	613	1,335	1,948	1,316	479,871
Middle Atlantic	4,063	1,702	1,704	4,061	5,765	4,062	1,194,963
East North Central	3,403	2,033	2,010	3,426	5,436	3,414	1,183,008
West North Central	867	671	624	914	1,538	891	314,342
South Atlantic	700	384	508	576	1,084	638	240,828
East South Central	272	233	285	220	505	246	62,612
West South Central	851	461	233	1,079	1,312	965	386,481
Mountain	231	205	195	241	436	236	82,984
Pacific	1,621	1,256	1,240	1,637	2,877	1,629	576,274

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ Includes nine deaths reported during 1969.

TABLE 7. UTILIZATION INDICES IN INPATIENT SERVICE OF RESIDENTIAL TREATMENT CENTERS BY BED SIZE AND GEOGRAPHIC DIVISION: UNITED STATES, 1969 1/

(Definitions of terms are given in Appendix I)

Bed Size and Geographic Division	Utilization Indices							Rates per 100,000 U.S. Resident Population Under 18 years 2/		
	Caseload Indices per Facility				Additions per 100 Beds 3/	Additions per 100 Average Resident Patients	Additions per 100 Discharges	Annual Additions	Average Resident Patients	Annual Days of Care
	Aver. No. of Beds 3/	Aver. Daily Census	Aver. Daily % Occ'pcy	Aver. Yearly Add'ts.						
All RTC's	58	47	81	29	50	57	102	10	19	6,391
Bed Size										
Less than 25 beds	18	14	78	12	71	84	103	1	1	444
25-49 beds	35	30	86	21	58	65	102	3	5	1,663
50-74 beds	59	50	85	32	54	62	102	2	4	1,253
75-99 beds	86	65	76	46	55	68	99	1	1	533
100 beds and over	223	179	80	86	38	42	103	3	8	2,498
Geographic Division										
New England	43	37	86	18	42	49	106	17	34	12,311
Middle Atlantic	113	86	76	45	40	42	100	14	33	9,787
East North Central	49	41	84	25	52	60	101	14	24	8,295
West North Central	34	28	82	22	64	75	108	12	16	5,577
South Atlantic	58	47	81	27	47	60	76	4	6	2,227
East South Central	**	**	**	**	**	**	**	**	**	**
West South Central	119	106	89	46	39	48	198	6	14	5,413
Mountain	30	25	83	23	76	87	105	7	8	2,702
Pacific	45	40	89	32	71	77	101	14	18	6,377

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix I).

2/ The population used in the calculation of these rates was the civilian resident population under 18 years of age in the United States as of July 1, 1969. Source: Current Population Reports, Series P-25, No. 437, January 16, 1970.

3/ Beds set up and staffed for use as of December 31, 1969.

TABLE 8. NUMBER OF EMPLOYEES AND MANHOURS WORKED IN A WEEK 1/ IN RESIDENTIAL TREATMENT CENTERS BY WHETHER FULL-TIME EMPLOYEE, PART-TIME EMPLOYEE OR TRAINEE, AND STAFF DISCIPLINE: UNITED STATES, JANUARY 1970 2/

(Definitions of terms are given in Appendix I)

Staff Discipline	All Employees			Full-time Employees		
	Persons Employed	Hours Worked	Average Hours per Person	Persons Employed	Hours Worked	Average Hours per Person
All Employees	14,752	486,949	33.0	10,412	421,238	40.5
Psychiatrists	466	4,745	10.2	35	1,362	38.9
Psychologists - Total	398	8,878	22.3	142	5,558	39.1
Psychologists - MA and above	348	7,471	21.5	119	4,646	39.0
Psychologists - Other	50	1,407	28.1	23	912	39.7
Social Workers - Total	1,630	52,217	32.0	1,127	44,717	39.7
Social Workers - MA and above	1,233	40,186	32.6	886	35,311	39.9
Social Workers - Other	397	12,031	30.3	241	9,406	39.0
Registered Nurses 3/	203	5,990	29.5	123	4,828	39.3
Counselors, Therapists and their Assistants	678	19,578	28.9	361	14,646	40.6
Vocational Rehabilitation Counselors	104	2,818	27.1	65	2,354	36.2
Occupational Therapists	68	1,936	28.5	37	1,477	39.9
Recreational Therapists	506	14,824	29.3	259	10,815	41.8
Health Professionals, not elsewhere classified	934	24,256	26.0	467	19,558	41.9
Physicians (non-psychiatrist)	170	1,007	5.9	6	274	45.7
Other Mental Health Professionals	536	19,142	35.7	389	16,147	41.5
Other Health Professionals and Assistants 4/	228	4,107	18.0	72	3,137	43.6
School Teachers - BA and above	1,542	49,777	32.3	1,103	42,691	38.7
Semi-Professional and Non-Professional Health Workers 5/	4,643	173,756	37.4	3,617	153,942	42.6
All Other Personnel (e.g., clerical, fiscal, maintenance, etc.)	4,258	147,752	34.7	3,437	133,936	39.0

Staff Discipline	Part-time Employees			Trainees, Residents and/or Interns		
	Persons Employed	Hours Worked	Average Hours per Person	Persons Employed	Hours Worked	Average Hours per Person
All Employees	3,721	56,031	15.1	619	9,680	15.6
Psychiatrists	374	2,925	7.8	57	458	8.0
Psychologists - Total	214	2,217	10.4	42	1,103	26.3
Psychologists - MA and above	196	2,015	10.3	33	810	24.5
Psychologists - Other	18	202	11.2	9	293	32.6
Social Workers - Total	336	4,484	13.3	167	3,016	18.1
Social Workers - MA and above	281	3,616	12.9	66	1,259	19.1
Social Workers - Other	55	868	15.8	101	1,757	17.4
Registered Nurses 3/	67	1,036	15.5	13	126	9.7
Counselors, Therapists and their Assistants	257	4,542	17.7	60	390	6.5
Vocational Rehabilitation Counselors	21	311	14.8	18	153	8.5
Occupational Therapists	21	407	19.4	10	52	5.2
Recreational Therapists	215	3,824	17.8	32	185	5.8
Health Professionals, not elsewhere classified	434	4,239	9.7	33	459	13.9
Physicians (non-psychiatrist)	160	719	4.5	4	14	3.5
Other Mental Health Professionals	126	2,616	20.8	21	379	18.0
Other Health Professionals and Assistants 4/	148	904	6.1	8	66	8.2
School Teachers - BA and above	355	5,758	16.2	84	1,328	15.8
Semi-Professional and Non-Professional Health Workers 5/	908	17,883	19.7	118	1,931	16.4
All Other Personnel (e.g., clerical, fiscal, maintenance, etc.)	776	12,947	16.7	45	869	19.3

1/ The week for which data were requested in the survey was January 11-17, 1970.
2/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).
3/ Student nurses are included in "trainee" and "all employees" columns.
4/ Includes dentists, dental technicians, pharmacists, dieticians, etc.
5/ Includes licensed practical nurses, aides, attendants and psychiatric technicians, house parents, case aides, companions, etc.

TABLE 9. PERCENT DISTRIBUTION OF EMPLOYEES AND MANHOURS WORKED IN A WEEK[1] IN RESIDENTIAL TREATMENT CENTERS, BY STAFF DISCIPLINE AND PROFESSIONAL STATUS ACCORDING TO EMPLOYMENT STATUS: UNITED STATES, JANUARY 1970[2]

(Definitions of terms are given in Appendix I)

Staff Discipline and Professional Status	Employment Status				Employment Status			
	All Employees	Full-time Employees	Part-time Employees	Trainees, Residents and/or Interns	All Employees	Full-time Employees	Part-time Employees	Trainees, Residents and/or Interns
	Number of Persons Employed				Number of Manhours Worked in Week			
All Employees	14,752	10,412	3,721	619	486,949	421,238	56,031	9,680
	Percent Distribution				Percent Distribution			
All Employees	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Professional Employees - Total	39.6	32.3	54.8	73.7	34.0	31.7	45.0	71.1
Psychiatrists	3.2	0.3	10.1	9.2	1.0	0.3	5.2	4.7
Psychologists	2.7	1.4	5.8	6.8	1.8	1.3	4.0	11.4
Social Workers	11.0	10.8	9.0	27.0	10.8	10.7	8.0	31.3
Registered Nurses[3]	1.4	1.2	1.8	2.1	1.2	1.1	1.8	1.3
School teachers - BA and above	10.4	10.6	9.5	13.6	10.2	10.2	10.3	13.7
Counselors and Therapists and their Assistants [4]	4.6	3.5	6.9	9.7	4.0	3.5	8.1	4.0
Health Professionals, not elsewhere classified[5]	6.3	4.5	11.7	5.3	5.0	4.6	7.6	4.7
Other Employees - Total	60.4	67.7	45.2	26.3	66.0	68.3	55.0	28.9
Semi-professional and non-professional health workers[6]	31.5	34.7	24.4	19.0	35.7	36.5	31.9	19.9
All other personnel (clerical, fiscal, maintenance, etc.)	28.9	33.0	20.8	7.3	30.3	31.8	23.1	9.0

1/ The week for which data were requested in the survey was January 11-17, 1970.
2/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).
3/ Student nurses included in "all employees" and "trainees" columns.
4/ Includes vocational rehabilitation counselors, occupational therapists, recreational therapists, and assistants to all three.
5/ Includes physicians exclusive of psychiatrists, dentists, dental technicians, pharmacists, dieticians, etc.
6/ Includes licensed practical nurses, aides, attendants, psychiatric technicians, house parents, case aides, companions, etc.

TABLE 10. PERCENT OF RESIDENTIAL TREATMENT CENTERS EMPLOYING PERSONS IN SELECTED PROFESSIONAL STAFF DISCIPLINES BY BED SIZE: UNITED STATES, JANUARY 1970[1]

(Definitions of terms are given in Appendix I)

Selected Professional Staff Disciplines and Bed Size	All RTC's	All Employees[2]		All RTC's	Full-time Employees	
		RTC's employing:			RTC's employing:	
		None	1 or more		None	1 or more
	Percent Distribution of RTC's			Percent Distribution of RTC's		
Psychiatrists						
All sizes	100.0	11.8	88.2	100.0	94.7	5.3
Less than 25 beds	100.0	21.6	78.4	100.0	92.2	7.8
25-49 beds	100.0	9.5	90.5	100.0	96.8	3.2
50-74 beds	100.0	8.9	91.1	100.0	93.3	6.7
75-99 beds	100.0	7.7	92.3	100.0	100.0	-
100 beds and over	100.0	8.4	91.6	100.0	91.7	8.3
Psychologists						
All sizes	100.0	35.1	64.9	100.0	73.7	26.3
Less than 25 beds	100.0	45.1	54.9	100.0	76.5	23.5
25-49 beds	100.0	40.0	60.0	100.0	82.1	17.9
50-74 beds	100.0	24.4	75.6	100.0	71.1	28.9
75-99 beds	100.0	46.2	53.8	100.0	76.9	23.1
100 beds and over	100.0	8.3	91.7	100.0	37.5	62.5
Social Workers						
All sizes	100.0	3.5	96.5	100.0	9.2	90.8
Less than 25 beds	100.0	9.8	90.2	100.0	27.5	72.5
25-49 beds	100.0	2.1	97.9	100.0	5.3	94.7
50-74 beds	100.0	-	100.0	100.0	-	100.0
75-99 beds	100.0	7.7	92.3	100.0	7.7	92.3
100 beds and over	100.0	-	100.0	100.0	4.2	95.8
Registered Nurses[3]						
All sizes	100.0	57.5	42.5	100.0	72.8	27.2
Less than 25 beds	100.0	78.4	21.6	100.0	88.2	11.8
25-49 beds	100.0	61.1	38.9	100.0	80.0	20.0
50-74 beds	100.0	44.4	55.6	100.0	57.8	42.2
75-99 beds	100.0	53.8	46.2	100.0	84.6	15.4
100 beds and over	100.0	25.0	75.0	100.0	33.3	66.7
School Teachers - BA and above						
All sizes	100.0	19.7	80.3	100.0	33.3	66.7
Less than 25 beds	100.0	27.5	72.5	100.0	41.2	58.8
25-49 beds	100.0	20.0	80.0	100.0	32.6	67.4
50-74 beds	100.0	20.0	80.0	100.0	35.6	64.4
75-99 beds	100.0	7.7	92.3	100.0	23.1	76.9
100 beds and over	100.0	8.3	91.7	100.0	20.8	79.2
Counselors & Therapists & their Assistants[4]						
All sizes	100.0	55.7	44.3	100.0	68.4	31.6
Less than 25 beds	100.0	60.8	39.2	100.0	72.5	27.5
25-49 beds	100.0	64.2	35.8	100.0	75.8	24.2
50-74 beds	100.0	53.3	46.7	100.0	66.7	33.3
75-99 beds	100.0	23.1	76.9	100.0	61.5	38.5
100 beds and over	100.0	33.3	66.7	100.0	37.5	62.5

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[1] This table includes estimates for nonreporting residential treatment centers. (See Appendix II)

[2] Includes full-time employees, part-time employees, and trainees, residents and/or interns.

[3] Student nurses are included under "all employees."

[4] Includes vocational rehabilitation counselors, occupational therapists, recreational therapists and assistants to all three.

TABLE 11. PERCENT DISTRIBUTION OF EMPLOYEES AND MANHOURS WORKED IN A WEEK[1] IN SELECTED PROFESSIONAL STAFF DISCIPLINES BY EMPLOYMENT STATUS AND BED SIZE: UNITED STATES, JANUARY 1970[2]

(Definitions of terms are given in Appendix I)

Selected Professional Staff Disciplines and Bed Size	Number of Em-ployees	Employment Status				Number of Man-hours	Employment Status			
		All Employees	Full-time Employees	Part-time Employees	Trainees, Residents and/or Interns		All Employees	Full-time Employees	Part-time Employees	Trainees, Residents and/or Interns
		Percent Distribution of Employees					Percent Distribution of Manhours			
Psychiatrists										
All sizes	466	100.0	7.5	80.3	12.2	4,745	100.0	28.7	61.7	9.6
Less than 25 beds	83	100.0	9.9	70.4	19.7	1,016	100.0	35.4	37.8	26.8
25-49 beds	191	100.0	4.1	76.6	19.3	1,434	100.0	21.8	68.5	9.7
50-74 beds	77	100.0	13.9	83.3	2.8	939	100.0	39.9	55.9	4.2
75-99 beds	22	100.0	-	100.0	-	185	100.0	-	100.0	-
100 beds and over	93	100.0	9.3	88.4	2.3	1,171	100.0	26.6	71.9	1.5
Psychologists										
All sizes	398	100.0	35.7	53.7	10.6	8,878	100.0	62.9	24.7	12.4
Less than 25 beds	67	100.0	31.6	54.4	14.0	1,423	100.0	59.1	26.2	14.7
25-49 beds	125	100.0	26.5	63.8	9.7	2,435	100.0	56.6	29.0	14.4
50-74 beds	85	100.0	39.2	51.9	8.9	2,034	100.0	65.1	22.7	12.2
75-99 beds	23	100.0	15.8	57.9	26.3	334	100.0	43.2	51.4	5.4
100 beds and over	98	100.0	51.1	41.1	7.8	2,652	100.0	71.1	18.4	10.5
Social Workers										
All sizes	1,630	100.0	69.1	20.7	10.2	52,217	100.0	85.2	9.0	5.8
Less than 25 beds	212	100.0	60.2	25.8	14.0	6,618	100.0	77.2	12.2	10.6
25-49 beds	616	100.0	68.8	19.6	11.6	19,985	100.0	86.8	6.8	6.4
50-74 beds	451	100.0	67.7	20.7	11.6	14,069	100.0	83.9	10.0	6.1
75-99 beds	66	100.0	74.6	21.8	3.6	2,132	100.0	90.5	7.5	2.0
100 beds and over	285	100.0	77.1	19.0	3.9	9,413	100.0	88.4	9.9	1.7
Registered Nurses[3]										
All sizes	203	100.0	60.6	33.0	6.4	5,990	100.0	80.6	17.3	2.1
Less than 25 beds	18	100.0	66.6	26.7	6.7	510	100.0	91.6	7.7	0.7
25-49 beds	74	100.0	48.5	34.8	16.7	1,772	100.0	77.8	15.2	7.0
50-74 beds	45	100.0	73.2	26.8	-	1,423	100.0	91.0	9.0	-
75-99 beds	6	100.0	40.0	60.0	-	175	100.0	51.7	48.3	-
100 beds and over	60	100.0	64.3	35.7	-	2,110	100.0	75.6	24.4	-
School Teachers - BA and above										
All sizes	1,542	100.0	71.5	23.0	5.5	49,777	100.0	85.9	11.6	2.5
Less than 25 beds	150	100.0	58.8	19.0	22.2	4,424	100.0	77.5	8.7	13.7
25-49 beds	365	100.0	81.4	15.5	3.1	12,469	100.0	91.8	6.8	1.4
50-74 beds	306	100.0	70.5	26.3	3.2	9,789	100.0	82.7	14.1	3.2
75-99 beds	170	100.0	57.9	42.1	-	5,093	100.0	86.6	13.4	-
100 beds and over	551	100.0	72.7	21.7	5.6	18,002	100.0	85.0	13.6	1.4
Counselors and Therapists & their Assts[4]										
All sizes	678	100.0	53.3	37.9	8.8	19,578	100.0	75.1	23.0	1.9
Less than 25 beds	51	100.0	47.7	40.9	11.4	1,200	100.0	73.7	21.8	4.5
25-49 beds	146	100.0	49.2	34.1	16.7	4,069	100.0	75.2	22.8	2.0
50-74 beds	69	100.0	35.9	57.8	6.3	1,673	100.0	62.0	37.0	1.0
75-99 beds	36	100.0	30.0	23.3	46.7	719	100.0	61.5	18.8	19.7
100 beds and over	376	100.0	60.8	36.6	2.6	11,917	100.0	77.7	21.5	0.8

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[1] The week for which data were requested in the survey was January 11-17, 1970.

[2] This table includes estimates for nonreporting residential treatment centers (see Appendix II).

[3] Student nurses are included in "trainee" and "all employees" columns.

[4] Includes vocational rehabilitation counselors, occupational therapists, recreational therapists and assistants to all three.

TABLE 14. NUMBER OF MANHOURS WORKED IN A WEEK[1/], NUMBER OF FULL-TIME EQUIVALENTS AND NUMBER OF FULL-TIME EQUIVALENTS PER 1,000 RESIDENTS IN RESIDENTIAL TREATMENT CENTERS BY GEOGRAPHIC DIVISION AND SELECTED PROFESSIONAL STAFF DISCIPLINES: UNITED STATES, JANUARY 1970[2/]

(Definitions of terms are given in Appendix I)

Selected Professional Staff Disciplines	United States	Geographic Division								
		New England	Middle Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific
		Number of Manhours Worked in Week[1/] [3/]								
Psychiatrists	4,745	1,048	1,412	1,092	228	417	12	153	68	315
Psychologists	8,878	1,933	2,670	1,264	657	527	75	432	209	1,111
Social Workers	52,217	5,867	11,367	15,378	4,957	2,013	501	1,236	1,016	9,882
Registered Nurses[4/]	5,990	979	1,690	1,419	197	977	79	191	3	455
School Teachers - BA and above	49,777	7,955	11,747	13,672	3,213	4,148	1,761	3,062	622	3,597
Counselors and Therapists & their Assistants [5/]	19,578	1,088	8,046	3,310	1,706	766	271	413	25	3,953
		Number of Full-Time Equivalents[6/]								
Psychiatrists	119	26	35	27	6	10	**	4	2	8
Psychologists	222	48	67	32	16	13	**	11	5	28
Social Workers	1,305	147	284	384	124	50	12	31	25	247
Registered Nurses[4/]	150	24	42	35	5	24	**	5	**	11
School Teachers - BA and above	1,244	199	294	342	80	104	44	77	15	90
Counselors and Therapists & their Assistants [5/]	489	27	201	83	43	19	7	10	**	99
		Number of Full-Time Equivalents per 1,000 Residents[7/]								
Psychiatrists	9	20	9	8	6	18	**	4	7	5
Psychologists	16	36	16	9	18	23	**	10	22	17
Social Workers	97	110	70	112	136	87	57	29	105	151
Registered Nurses[4/]	11	18	10	10	5	42	**	4	**	7
School Teachers - BA and above	92	149	72	100	88	180	200	71	65	55
Counselors and Therapists and their Assistants [5/]	36	20	50	24	47	33	31	10	**	60

[1/] The week for which staff data were requested in the survey was January 11-17, 1970.

[2/] This table includes estimates for nonreporting residential treatment centers (see Appendix II).

[3/] Includes hours worked by full-time employees, part-time employees, trainees, etc.

[4/] Includes student nurses.

[5/] Includes vocational rehabilitation counselors, occupational therapists, recreational therapists and assistants to all three.

[6/] Full-time equivalent is taken as a 40-hour work week.

[7/] Patients resident in RTC's on December 31, 1969. (See Table 6)

TABLE 15. NUMBER AND PERCENT DISTRIBUTION OF EXPENDITURES IN RESIDENTIAL TREATMENT CENTERS BY TYPE OF EXPENDITURE AND BED SIZE: UNITED STATES, 1969

(Definitions of terms are given in Appendix I).

Bed Size	Total Expenditures	Operating Expenditures			Capital Expenditures
		Total Operating Expenditures	Salaries	Other Operating Expenditures	
	Annual Expenditures in Thousands of Dollars				
All sizes	$121,383	$106,485	$67,959	$38,526	$14,898
Less than 25 beds	11,460	9,912	6,546	3,366	1,548
25-49 beds	34,671	30,182	20,007	10,175	4,489
50-74 beds	27,366	25,649	16,868	8,781	1,717
75-99 beds	7,304	6,431	3,723	2,708	873
100 beds and over	40,582	34,311	20,815	13,496	6,271
	Percent Distribution of Expenditures				
All sizes	100.0	87.7	56.0	31.7	12.3
Less than 25 beds	100.0	86.5	57.1	29.4	13.5
25-49 beds	100.0	87.1	57.7	29.4	12.9
50-74 beds	100.0	93.7	61.6	32.1	6.3
75-99 beds	100.0	88.0	51.0	37.0	12.0
100 beds and over	100.0	84.5	51.3	33.2	15.5

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ For inclusions under each type of expenditure, see Section entitled "Expenditures."

TABLE 16. NUMBER AND PERCENT DISTRIBUTION OF EXPENDITURES IN RESIDENTIAL TREATMENT CENTERS BY TYPE OF EXPENDITURE AND GEOGRAPHIC DIVISION: UNITED STATES, 1969 1/

(Definitions of terms are given in Appendix I)

Geographic Division	Total Expenditures 2/	Operating Expenditures 2/			Capital Expenditures 2/
		Total Operating Expenditures	Salaries	Other Operating Expenditures	
	Annual Expenditures in Thousands of Dollars				
United States	$121,383	$106,485	$67,959	$38,526	$14,898
New England	17,708	15,052	10,241	4,811	2,656
Middle Atlantic	32,858	30,635	18,038	12,597	2,223
East North Central	30,986	27,577	17,739	9,838	3,409
West North Central	7,883	7,641	4,866	2,775	242
South Atlantic	8,259	4,766	3,334	1,432	3,493
East South Central	2,071	1,865	1,425	440	206
West South Central	4,119	3,861	2,184	1,677	258
Mountain	1,536	1,512	964	548	24
Pacific	15,963	13,576	9,168	4,408	2,387
	Percent Distribution of Expenditures				
United States	100.0	87.7	56.0	31.7	12.3
New England	100.0	85.0	57.8	27.2	15.0
Middle Atlantic	100.0	93.2	54.9	38.3	6.8
East North Central	100.0	89.0	57.2	31.8	11.0
West North Central	100.0	96.9	61.7	35.2	3.1
South Atlantic	100.0	57.7	40.4	17.3	42.3
East South Central	100.0	**	**	**	**
West South Central	100.0	93.7	53.0	40.7	6.3
Mountain	100.0	98.4	62.8	35.6	1.6
Pacific	100.0	85.0	57.4	27.6	15.0

1/ This table includes estimates for nonreporting residential treatment centers (see Appendix II).

2/ For inclusions under each type of expenditure, see Section entitled "Expenditures."

APPENDIX I. DEFINITION OF TERMS USED IN THIS REPORT

Residential Treatment Centers and Terms Used to Classify Them

Residential Treatment Center for Emotionally Disturbed Children.—A residential institution that primarily serves children who by clinical diagnosis are moderately or seriously disturbed and provides treatment services usually under the supervision of a psychiatrist. These facilities are also referred to in this report as RTC's or residential treatment centers.

Geographic Division.—For the purpose of classifying RTC's by geographic area, the States are grouped into the following nine geographic divisions, which correspond to those used by the Bureau of the Census:

Geographic Division	*States Included*
New England	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut
Middle Atlantic	New York, New Jersey, Pennsylvania
East North Central	Michigan, Ohio, Illinois, Indiana, Wisconsin
West North Central	Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas
South Atlantic	Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida
East South Central	Kentucky, Tennessee, Alabama, Mississippi
West South Central	Arkansas, Louisiana, Oklahoma, Texas
Mountain	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada
Pacific	Washington, Oregon, California, Hawaii, Alaska

United States.—The 50 States and the District of Columbia.

Types of Direct Service

Aftercare Service.—Provision of mental health services on an outpatient basis to persons previously hospitalized for mental illness, with the goal of enabling the patient to achieve a maximum level of functioning, or to avoid rehospitalization or both.

Day/Night Treatment Service.—Provision of a planned therapeutic program during most or all of the day (day treatment) or during the evening or night (night treatment) to persons who need broader programs than are possible through outpatient visits, but who do not require full-time hospitalization.

Day Training Service.—Provision to children and adolescents of training in self-help and motor skills, activities of daily living, and social development preliminary to special education or other placement.

Diagnostic Service.—Medical, psychiatric, social or psychological diagnosis and evaluation of persons to determine the person's needs and proper placement.

Halfway House Service.—Preparing a previously institutionalized patient for return to home and community environment by providing transitional living quarters and assistance in activities of daily living.

Inpatient Treatment Service.—Provision of mental health treatment to persons requiring 24-hour supervision.

Outpatient Treatment Service.—Provision of mental health treatment on an outpatient basis to persons who do not require either full-time or partial hospitalization.

Special Education Service.—Provision of educational services to children and adolescents unable to participate in the regular school system.

Vocational Rehabilitation Service.—Retraining of persons in vocational and social skills, habits and attitudes to assist in job recruitment and placement.

Work Activity Service.—Provision of work-orientated tasks and activities of daily living for adults to prepare for sheltered employment or vocational rehabilitation.

Types of Research, Education and Training Activities

Consultation to Community Agencies and Their Staff.—A service provided to another professional person or group in which the consultant uses his special skills and knowledge with the goal of expediting solutions to problems presented by the consultee. This includes all forms of mental health consultation ranging from individual case consultation on behalf of another professional, through group consultations to program or administrative consultations.

General Public Education.—Those activities which are planned to teach the public about mental health or illness in general or to explain the operation of the mental health agency or program.

In-service Training to Staff of This Facility.—Formal instructions and supervisory activities for students, trainees, or staff employed by the residential treatment centers.

In-service Training to Staff of Community Agencies.—Activities which are planned to instruct the workers of other agencies or professional groups about the mental health aspects of their work. The focus is on the teaching of mental health principles and/or techniques. These activities exclude instruction and supervisory activities for students or trainees on the facilities' own staffs.

Program Evaluation.—A formal program designed to assess the effectiveness and efficiency of mental health programs.

Research.—Basic, clinical, or sociocultural research on a formal basis about the nature, cause, prevention, and treatment of mental or behavioral disorders.

Measures of Patient Movement and Annual Volume of Service

Residents at Beginning of Year.—Includes persons receiving inpatient services in residential treatment centers on the first day of 1969 or who were away on short visits but were expected to return to the inpatient service.

Additions During Year.—Includes admissions and readmissions as well as persons returned from long-term leave and persons transferred from noninpatient components of the RTC's.

Patients Under Care During Year.—Patients under care during the year is approximated by the sum of the "residents at beginning of year" and "additions during the year."

Discontinuations During Year.—Persons discharged from RTC's either alive or by death, persons placed on long-term leave, and those transferred to noninpatient components of the RTC's.

Residents at End of Year.—Persons who were receiving inpatient services in residential treatment centers on the last day of 1969.

Average Resident Patients.—The average of the "residents at the beginning of the year" and "residents at the end of the year."

Days of Care.—Days of inpatient care provided to persons in RTC's during 1969. Excludes days for which patient was on overnight or weekend pass, or other short-term leave. Also referred to in this report as "patient days."

Utilization Indices

Average Daily Census.—The average daily number of persons resident as inpatients which is the total annual days of care provided to inpatients divided by the total number of days in a year (365 in 1969).

Average Daily Census per RTC.—The average daily census (see above definition) for a particular group (e.g. RTC's 25–49 beds) divided by the number of RTC's in that group.

Average Percent Occupancy per RTC.—The ratio, expressed as a percent, of the average daily census per RTC (average number of residents occupying inpatient beds daily) to the average number of beds available per RTC.

Average Annual Additions.—The total number of annual additions (see definition) occurring in a group (e.g. RTC's in Middle Atlantic Division) divided by the number of RTC's in that group.

Additions per 100 Beds.—The total number of annual additions occurring in a group of RTC's per 100 inpatient beds in that group.

Staffing

Full-Time Employees.—Persons employed 35 hours or more a week (excludes trainees).

Part-Time Employees.—Persons employed less than 35 hours a week.

Trainees.—Trainees, residents, and interns regardless of number of hours worked in a week.

Professional Employees.—Professional employees include psychiatrists, other physicians, psychologists, social workers, registered nurses, and other professional staff such as occupational and recreational therapists, vocational counselors, teachers and other mental health and health professionals, not otherwise classified.

Nonprofessional Employees.—Employees not classified as "professional."

Manhour.—A unit of one hours' work by one employee.

Full-Time Equivalents.—The total manhours worked by full-time employees, part-time employees and trainees in each staff discipline divided by 40 hours to indicate the number of persons working a 40-hour week to provide this many manhours.

APPENDIX II. ESTIMATION PROCEDURES FOR NONREPORTING RESIDENTIAL TREATMENT CENTERS AND OTHER FACILITIES

All tables, except Tables 1 and 3 (types of service provided by State), have been adjusted to include estimates for residential treatment centers which either did not respond to the survey or which did not report specific items. The decision to adjust the data was based on the high response rate to all items on the "Inventory," ranging from 84 percent of the 261 RTC's responding for expenditure data to 96 percent providing information on types of service. The adjustments were made on the assumption that characteristics of nonrespondents within each of the bed size groups and geographic divisions were similar to those RTC's that responded. Table I shows the response rate of RTC's with regard to specific items; Table II gives estimates of nonresponse frequencies for specific items such as number of additions, number of discontinuations, etc.

Since number of inpatient beds is in general proportionate to number of additions, discontinuations, days of care and other measures, the ratio of known number of beds to beds reported within a bed size class or geographic division was used as an adjustment factor. Another supplemental adjustment factor, which is the ratio of all known RTC's in a group to the number reporting a specific item, was used to adjust those facilities in which bed size was *not* reported.

Similar adjustments were also used for nonresponse among other types of facilities such as psychiatric hospitals for children, private mental hospitals and others. Table III shows the response rate of these other facilities.

TABLE I. DISTRIBUTION OF RESIDENTIAL TREATMENT CENTERS BY RESPONSE TO SPECIFIC ITEMS ON THE 1969 INVENTORY OF MENTAL HEALTH FACILITIES

Data Item and Group	Number of RTC's Surveyed	Response		Nonresponse	
		Number of RTC's	Percent	Number of RTC's	Percent
Number of Beds	261	250	95.8	11	4.2
RTC's by States	261	261	100.0	-	-
RTC's by Geographic Division	261	261	100.0	-	-
Type of Ownership	261	250	95.8	11	4.2
Types of Services Provided					
By Bed Size	261	250	95.8	11	4.2
By Geographic Division 1/	261	250	95.8	11	4.2
New England	36	33	91.7	3	8.3
Middle Atlantic	38	38	100.0	-	-
East North Central	80	78	97.5	2	2.5
West North Central	31	29	93.5	2	6.5
South Atlantic	14	13	92.9	1	7.1
East South Central	4	3	75.0	1	25.0
West South Central	10	9	90.0	1	10.0
Mountain	9	9	100.0	-	-
Pacific	39	38	97.4	1	2.6
Diagnostic Restrictions					
By Bed Size	261	246	94.3	15	5.7
Age Restrictions					
By Bed Size	261	250	95.8	11	4.2
By Geographic Division	261	250	95.8	11	4.2
Patient Movement and Volume of Service					
By Bed Size	261	228	87.4	33	12.6
By Geographic Division	261	228	87.4	33	12.6
New England	36	31	86.1	5	13.9
Middle Atlantic	38	37	97.4	1	2.6
East North Central	80	67	83.8	13	16.2
West North Central	31	28	90.3	3	9.7
South Atlantic	14	12	85.7	2	14.3
East South Central	4	2	50.0	2	50.0
West South Central	10	9	90.0	1	10.0
Mountain	9	7	77.8	2	22.2
Pacific	39	35	89.7	4	10.3
Number and Types of Employees					
By Bed Size	261	228	87.4	33	12.6
By Geographic Division	261	228	87.4	33	12.6
Expenditures					
By Bed Size	261	218	83.5	43	16.5
By Geographic Division	261	218	83.5	43	16.5
New England	36	28	77.8	8	22.2
Middle Atlantic	38	36	94.7	2	5.3
East North Central	80	63	78.8	17	21.2
West North Central	31	28	90.3	3	9.7
South Atlantic	14	12	85.7	2	14.3
East South Central	4	2	50.0	2	50.0
West South Central	10	6	60.0	4	40.0
Mountain	9	7	77.8	2	22.2
Pacific	39	36	92.3	3	7.7

1/ Estimates of services by State are shown in Tables 1 and 3 of this report.

TABLE II. ESTIMATED SELECTED PATIENT MOVEMENT, EXPENDITURE, AND STAFFING DATA BY BED SIZE AND GEOGRAPHIC DIVISION: NONREPORTING RESIDENTIAL TREATMENT CENTERS, UNITED STATES, 1969

Bed Size and Geographic Division	Patient Movement				Days of Care	Total Expenditures ($000's)	Social Workers	
	Residents at Beginning of Year	Additions During Year	Discontinuations During Year	Residents at End of Year			Number of Employees	Number of Hours
Total	1,413	905	897	1,421	490,850	$18,017	179	5,944
Bed Size								
Less than 25 beds	141	128	124	145	50,195	2,379	34	1,078
25-49 beds	381	272	269	384	136,808	3,729	71	2,388
50-74 beds	199	138	138	199	71,607	4,706	36	1,182
75-99 beds	188	133	135	186	66,146	1,243	11	380
100 beds and over	504	234	231	507	166,094	5,960	27	916
Geographic Division								
New England	172	86	81	177	63,682	4,559	30	779
Middle Atlantic	38	16	16	38	11,173	675	4	106
East North Central	629	376	371	634	218,662	7,993	82	2,842
West North Central	105	81	76	110	38,192	958	17	602
South Atlantic	55	30	40	45	18,989	651	6	159
East South Central	124	106	129	101	28,460	672	4	163
West South Central	85	46	23	108	38,648	1,459	3	124
Mountain	47	42	40	49	16,967	314	5	208
Pacific	158	122	121	159	56,077	736	28	961

TABLE III. DISTRIBUTION OF FACILITIES OTHER THAN RESIDENTIAL TREATMENT CENTERS SHOWN IN THIS REPORT BY RESPONSE TO SELECTED ITEMS ON THE 1969 INVENTORY OF MENTAL HEALTH FACILITIES

Type of Facility and Data Item	Number of Facilities Surveyed	Response		Nonresponse	
		Number of Facilities	Percent	Number of Facilities	Percent
Psychiatric Hospitals for Children					
Patient Movement and Volume of Service	15	13	86.7	2	13.3
Staffing	15	13	86.7	2	13.3
Expenditures	15	12	80.0	3	20.0
State and County Mental Hospitals					
Patient Movement and Volume of Service	310	287	92.6	23	7.4
Staffing	310	293	94.5	17	5.5
Expenditures	310	288	92.9	22	7.1
Private Mental Hospitals					
Patient Movement and Volume of Service	152	129	84.9	23	15.1
Staffing	152	128	84.2	24	15.8
Expenditures	152	113	74.3	39	25.7
General Hospitals with Separate Psychiatric Inpatient Facilities 1/					
Patient Movement and Volume of Service	663	546	82.4	117	17.6
Staffing	663	535	80.7	128	19.3
Expenditures	**	**	**	**	**

1/ Excludes general hospitals affiliated with federally funded community mental health centers.

"Changes in Age-Sex Diagnostic Composition of First Admissions to State and County Mental Hospitals—1962–1969"—Statistical Note 55; and "Trends in First Admission and Resident Patients Under 18 Years of Age by Diagnosis, Selected States 1966–1968"—Statistical Note 19 by Survey and Reports Section, Biometry Branch, Office of Program Planning and Evaluation, N.I.M.H., D.H.E.W.

CHANGES IN THE AGE-SEX-DIAGNOSTIC COMPOSITION OF FIRST ADMISSIONS TO STATE AND COUNTY MENTAL HOSPITALS—1962 TO 1969

First admissions[1] to State and county mental hospitals increased in number from 130,000 in 1962 to 164,000 in 1969, an increase of 25 percent. This increase was almost three times as great as the percent increase in the U.S. population over this interval. The first admission rate per 100,000 population increased from 70.6 in 1962 to 82.1 in 1969, an increase of 15 percent. Concurrent with these changes in the number and rate of first admissions have been other changes in the State hospital population, for example: a steady decrease in the resident population from 473,627 in 1962 to 366,815 in 1969, an increase in readmissions from 150,000 in 1962 to 216,000 in 1969, a decrease in the average length of stay of admissions, and many other factors. Other Notes in this series have documented some of these trends.[2] This Note examines in detail the changes in the number and rate of first admissions for selected age, sex, and diagnostic groups.

Table 1 shows the number and rate of first admissions for age and sex groups for 1962, 1965, and 1969. Table 2 shows the percent change in the number and rate of first admissions. The most striking fact these data document is the large increase in number and rate of first admissions, both male and female, in the under 15 and 15–24 year age groups and the large decrease, particularly from 1965 to 1969, in the number and rate of first admissions 65 years and older. It is useful to remember in reviewing these tables that the change in the rate per 100,000 population is a function algebraically of the changes in the number of first admissions for a given age group and the changes in the number of persons in the U.S. population in that age group. For example, the number of females under 15 in the general population increased only 1.9 percent between 1962 and 1969. First admissions in this age-sex group more than doubled in number over this interval, leading to a doubling in the rate per 100,000 population. Female first admissions 65 years and over decreased 40 percent between 1962–1969, while this age-sex group in the general population increased 17 percent, leading to over a 50 percent reduction in the rate per 100,000 population.

Age and sex differentials in the rate of change in the number and rate of first admissions have caused changes in the age-sex composition of this population of admissions. Table 3 illustrates changes produced in the age distribution of first admissions within sex groups over this interval. For example, first admissions aged 65 and over in 1962 constituted 22 percent of the total; in 1969 these admissions constituted 12 percent of the total. First admissions under 24 years of age increased from 18 percent of the total in 1962 to 27 percent of the total in 1969.

That fact that in general the number and rate of first admissions for males have increased relatively more than females is illustrated by the changes in the sex ratio (males per 100 females) and in the ratio of the male to female first admission rate per 100,000 population (Table 4). Some significant exceptions to the above generalization are the under 15 year and 65 and over age group. In the under 15 year age group, the increase in the number and rate of females exceeded considerably that for males between 1962 and 1965. Consequently, the number of females relative to males increased, reflected in a decrease in the sex ratio from 209 in 1962 to 160 in 1969. Concurrently, the ratio of the male to female first admission rate in this age group decreased from 2.03 to 1.54 between 1962 and 1969.

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[1] First admissions for the purposes of this Note are defined as admissions with no prior inpatient psychiatric care. Previous Notes in this series have examined State and county hospital admissions classified by whether they had experienced previous State and county inpatient hospital care (Statistical Notes 33 and 39).

[2] Note 1, for example, discusses changes in the resident population, Note 14 discusses trends from 1966–1968 by State in the number and rate of first admissions and resident paitents, and Note 40 presents data for 1970 on the dynamics of the hospital population.

Between 1965 and 1969 among the 65 and over age group, female first admissions have decreased considerably more in number and rate than males, causing the sex ratio to increase from 105 in 1965 to 145 in 1969, and the ratio of male to female admission rates to increase from 1.35 in 1965 to 1.95 in 1969.

Equally significant changes have occurred in the diagnostic composition of first admissions as illustrated in Table 5. Alcohol disorders[3] accounting for 15 percent of the total in 1962, now account for 18 percent. Drug abuse disorders increased from 1.3 percent to 3.9 percent of the total, while schizophrenia, accounting for 21 percent in 1962, in 1969 accounted for 15 percent. Largely as a result of the relative decrease in the 65 and over admissions, brain syndromes decreased in importance from 26 percent of the total to 16 percent between 1962 and 1969.

Changes in the number and rate of first admissions with schizophrenia, by age, are shown in Table 6. Despite an overall decrease for all age groups of ten percent in the number and 17 percent in the rate, both the number and rate increased in all but the age groups between 25 and 44. While the number and rate for the under 25 increased, the percent first admissions with schizophrenia was of the total admissions in this age group decreased, from 31 percent in 1962 to 19 percent in 1969. In contrast, in the 25–34 year age group, schizophrenia, which accounted for 36 percent of the total first admissions in 1962, in 1969 accounted for 20 percent.

Changes of an even greater magnitude have occurred for first admissions with alcohol disorders. Table 7 shows these changes for males in the age groups between 26 and 64. Selecting one age group, the 45–64 year olds, for illustration, it can be seen that there has been a 72 percent increase in the number of first admissions and a 60 percent increase in the rate. Alcohol disorders[3] which in 1962 accounted for 39 percent of the first admissions in this age group, accounted for 48 percent or almost half of the total in 1969.

Despite these changes, the three leading diagnoses among male first admissions in 1969 are almost identical to the pattern for 1962. Table 8 shows the three leading diagnoses for selected age-sex groups for 1962 and 1969. As can be seen, the only changes for males are (1) drug disorders have replaced mental retardation as the third leading diagnosis in the 15–24 year age group, and (2) alcohol disorders have replaced schizophrenia as the leading diagnosis in the 25–34 year age group.

For females, there has been more change in the three leading diagnoses between 1962 and 1969. Organic Brain Syndromes, the leading diagnosis for all ages in 1962, ranked third in 1969. *Schizophrenia was the second leading diagnosis for all ages in both 1962 and 1969. However, Schizophrenia was the leading diagnosis in the 25–34, 35–44 and 45–54 year age groups in 1962, and in 1969 it was second leading diagnosis in these age groups.* (*Table 8*)

The data shown for 1962 and 1965 are based on our annual census for those years of State and county mental hospitals conducted by NIMH in cooperation with the State Mental Health Authorities.

The data for 1969 are based on a sample survey of admissions to State and county mental hospital inpatient services conducted in October 1969 with the cooperation of the State Mental Health Authorities. The sample data have been inflated to represent a full year's admissions. This year interval is roughly equivalent to calendar year 1969. Because these data are derived from a sample, they are subject to sampling error. Preliminary estimates of the sampling error of the percentages shown are given in the table on next page.

RELATIVE STANDARD ERROR OF ESTIMATED RATES OR NUMBERS—PROVISIONAL ESTIMATES

Size of estimate (or numerator of rate)	Relative standard error (percent)
500	
1,000	11.1
5,000	8.6
10,000	6.0
25,000 or over	5.6
	5.0

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[3] Alcohol disorders include organic brain syndromes associated with alcoholism and alcohol addiction. The Second Edition of the American Psychiatric Association's Diagnostic and Statistical Manual (used in the 1969 Survey) introduced new alcoholism categories not in use in 1962 and 1965. In order to make the 1969 data comparable to the 1962 and 1965 data, those 1969 admissions classified under these new alcoholism categories are counted under "personality disorders." (See Table 5.)

STANDARD ERROR OF PERCENT (EXPRESSED IN PERCENTAGE POINTS)

Size or denominator	Estimated percent									
	5 or 95	10 or 90	15 or 85	20 or 80	25 or 75	30 or 70	35 or 65	40 or 60	45 or 55	50
5,000	0.68	0.93	1.11	1.24	1.35	1.43	1.48	1.52	1.55	1.56
10,000	.48	.66	.79	.88	.95	1.01	1.05	1.08	1.09	1.10
15,000	.39	.54	.64	.72	.78	.82	.86	.88	.89	.90
25,000	.30	.42	.50	.56	.60	.64	.66	.68	.69	.70
50,000	.21	.30	.35	.39	.43	.45	.47	.48	.49	.49
75,000	.18	.24	.29	.32	.35	.37	.38	.39	.40	.40
150,000	.12	.17	.20	.23	.25	.26	.27	.28	.28	.28
250,000	.10	.13	.16	.18	.19	.20	.21	.22	.22	.22
500,000	.07	.09	.11	.12	.13	.14	.15	.15	.15	.16

TABLE 1.—ADMISSIONS WITH NO PRIOR INPATIENT CARE TO STATE AND COUNTY MENTAL HOSPITALS, 1962, 1965, 1969

Age at admission and sex	Number of first admissions			Rate per 100,000 Population		
	1962	1965	1969	1962	1965	1969
Both sexes, all ages	129,698	144,090	163,984	70.6	75.1	82.1
Under 15	3,460	4,510	6,553	6.0	7.5	11.0
15 to 24	19,473	25,878	37,507	76.9	88.6	114.4
25 to 34	22,761	25,625	26,614	105.1	118.5	111.4
35 to 44	23,146	25,669	30,779	96.0	106.6	134.3
45 to 54	29,243	21,205	24,676	91.2	96.6	106.8
55 to 64	13,280	14,597	18,265	82.4	86.1	100.3
65 plus	28,335	26,606	19,591	163.7	146.5	100.6
Males, all ages	72,663	82,536	98,885	81.4	88.5	102.7
Under 15	2,339	2,971	4,036	7.9	9.7	13.4
15 to 24	11,330	15,352	22,552	94.4	109.3	145.5
25 to 34	12,301	14,361	16,389	119.1	138.7	142.7
35 to 44	12,938	14,774	17,292	111.6	127.3	156.6
45 to 54	11,442	12,711	16,805	111.0	119.3	151.2
55 to 64	7,731	8,749	10,229	99.5	107.7	118.6
65 plus	14,582	13,618	11,582	188.8	171.7	139.6
Females, all ages	57,035	61,554	65,099	60.4	62.4	63.0
Under 15	1,121	1,539	2,517	3.9	5.2	8.7
15 to 24	8,143	10,526	14,955	61.2	69.4	86.5
25 to 34	10,460	11,264	10,225	92.3	100.0	82.4
35 to 44	10,208	10,895	13,487	81.5	87.4	113.5
45 to 54	7,801	8,494	7,871	72.2	75.2	65.7
55 to 64	5,549	5,848	8,035	66.5	66.2	83.8
65 plus	13,753	12,988	8,009	143.5	127.0	71.7

TABLE 2.—PERCENT CHANGE IN THE NUMBER AND RATE PER 100,000 POPULATION OF ADMISSIONS WITH NO PRIOR INPATIENT CARE, STATE, AND COUNTY MENTAL HOSPITALS—1962, 1965, 1969

Age at admission and sex	Percent change: In number of 1st admissions 1962–65	Percent change: In number of 1st admissions 1965–69	Percent change: In rate per 100,000 population 1962–65	Percent change: In rate per 100,000 population 1965–69
Both sexes, all ages	+11.1	+13.8	+6.4	+9.3
Under 15	+30.3	+45.3	+25.0	+46.7
15 to 24	+32.9	+44.9	+15.2	+29.1
25 to 34	+12.6	+3.9	+12.7	−6.0
35 to 44	+10.9	+19.9	+11.0	+26.0
45 to 54	+10.2	+16.4	+5.9	+10.6
55 to 64	+9.9	+25.1	+4.5	+16.5
65 plus	−6.1	−26.4	−10.5	−31.3
Males, all ages	+13.6	+19.8	+8.7	+16.0
Under 15	+27.0	+35.8	+22.8	+38.1
15 to 24	+35.5	+46.9	+15.8	+33.1
25 to 34	+16.7	+14.1	+16.5	+2.9
35 to 44	+14.2	+17.0	+14.1	+23.0
45 to 54	+11.1	+32.2	+7.5	+26.7
55 to 64	+13.2	+16.9	+8.2	+10.1
65 plus	−6.6	−15.0	−9.1	−18.7
Females, all ages	+7.9	+5.8	+3.3	+1.0
Under 15	+37.3	+63.5	+33.3	+67.3
15 to 24	+29.3	+42.1	+13.4	+24.6
25 to 34	+7.7	−9.2	+8.3	−17.4
35 to 44	+6.7	+23.8	+7.2	+29.9
45 to 54	+8.9	−7.3	+4.2	−12.6
55 to 64	+5.4	+37.4	−.5	+26.6
65 plus	−5.6	−38.3	−11.5	−43.5

TABLE 3.—PERCENT DISTRIBUTION OF ADMISSIONS WITH NO PRIOR INPATIENT PSYCHIATRIC CARE BY AGE AND SEX, STATE AND COUNTY MENTAL HOSPITALS, 1962, 1965, AND 1969

Age at admission	Both sexes 1962	Both sexes 1965	Both sexes 1969	Males 1962	Males 1965	Males 1969	Females 1962	Females 1965	Females 1969
All ages	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 15	2.7	3.1	4.0	3.2	3.6	4.1	22.0	2.5	3.9
15 to 24	15.0	18.0	23.0	15.6	18.6	22.8	14.3	17.1	23.0
25 to 34	17.5	17.8	16.2	16.9	17.4	16.6	18.3	18.3	15.7
35 to 44	17.9	17.8	18.8	17.8	17.8	17.5	17.9	17.7	20.7
45 to 54	14.8	14.7	15.0	15.7	15.5	17.0	13.7	13.8	12.1
55 to 64	10.2	10.1	11.1	10.6	10.6	10.3	9.7	9.5	12.3
65 plus	21.9	18.5	11.9	20.1	16.5	11.7	24.1	21.1	12.3

TABLE 4.—SEX RATIO (RATES PER 100 FEMALES) AND THE RATIO OF THE MALE TO FEMALE ADMISSION RATE, ADMISSIONS WITH NO PRIOR INPATIENT PSYCHIATRIC CARE, STATE AND COUNTY MENTAL HOSPITALS, 1962, 1965, 1969

Age at admission	1962	1965	1969
Sex ratio (males per 100 females):			
All ages	127.4	134.1	151.9
Under 15	208.7	193.0	160.3
15 to 24	139.1	145.8	150.8
25 to 34	117.6	127.5	160.3
35 to 44	126.7	135.6	182.2
45 to 54	146.7	149.6	213.5
55 to 64	139.3	149.6	127.3
65 plus	106.0	104.9	144.6
Ratio of male to female admission rate per 100,000 population:			
All ages	1.35	1.42	1.63
Under 15	2.03	1.87	1.54
15 to 24	1.54	1.57	1.68
25 to 34	1.29	1.39	1.73
35 to 44	1.37	1.46	1.38
45 to 54	1.54	1.59	2.30
55 to 64	1.50	1.63	1.42
65 plus	1.32	1.35	1.95

TABLE 5.—NUMBER AND PERCENT DISTRIBUTION OF ADMISSIONS WITH NO PRIOR INPATIENT PSYCHIATRIC CARE TO STATE AND COUNTY MENTAL HOSPITALS FOR SELECTED DIAGNOSTIC GROUPS, 1962, 1965, AND 1969

Selected diagnostic groups [1]	1962	1965	1969
Number of 1st admissions:			
All diagnoses	129,698	144,090	163,984
Alcohol disorders [2]	19,406	24,380	29,894
Drug-abuse disorders	1,652	3,549	6,343
Brain syndromes (NEC)	33,978	31,345	25,548
Schizophrenia	27,266	25,374	24,540
Other psychoses	7,717	8,199	6,012
Neuroses	12,191	15,821	19,806
Personality disorders	12,957	18,112	26,804
All other diagnoses	14,531	17,310	25,037
Percent distribution:			
All disorders	100.0	100.0	100.0
Alcohol disorders [2]	15.0	16.9	18.2
Drug-abuse disorders	1.3	2.5	3.9
Brain syndromes (NEC)	26.2	21.8	15.6
Schizophrenia	21.0	17.6	15.0
Other psychoses	5.9	5.7	3.7
Neuroses	9.4	11.0	12.1
Personality disorders	10.0	12.6	16.3
All other diagnoses	11.2	11.9	15.2

[1] The diagnostic nomenclature used in this table was the "Diagnostic and Statistical Manual of Mental Disorders," 2d Ed. American Psychiatric Association, 1968. The codes corresponding to the diagnostic categories shown are as follows:

Diagnostic category and codes:
Alcohol disorders,* 291,309.13, 303.2.
Drug abuse disorders, 294.3, 309.14.
Brain syndromes (NEC), 290, 292–294.2, 294.4, 309.0–309.12, 309.2–309.9.
Schizophrenia, 295.
Other psychoses, 297–299.
Neuroses, 300.
Personality disorders,*301, 303.0–303.1, 303.9.

[2] Alcohol disorders include organic brain syndromes associated with alcoholism and alcohol addiction. The 2d Edition of the American Psychiatric Association's Diagnostic and Statistical Manual (used in the 1969 Survey) introduced new alcoholism categories not in use in 1962 and 1965. In order to make the 1969 data comparable to the 1962 and 1965 data, those 1969 admissions classified under these new alcoholism categories are counted under "personality disorders." (See Table 5.)

TABLE 6.—ADMISSIONS WITH NO PRIOR INPATIENT PSYCHIATRIC CARE, DIAGNOSED WITH SCHIZOPHRENIA, BY AGE, STATE AND COUNTY MENTAL HOSPITALS, 1962, 1965 AND 1969

Age at admission	1962	1965	1969	Percent change 1962–69
Number of 1st admissions:				
All ages	27,266	25,374	25,540	−10.0
Under 25	7,079	7,363	8,395	+18.6
25 to 34	8,090	7,161	5,333	−34.1
35 to 44	6,719	5,922	4,467	−33.5
45 to 54	3,575	3,273	4,050	+13.3
55 plus	1,803	1,655	2,296	+27.3
Rate per 100,000 population:				
All ages	14.8	13.2	12.3	−16.9
Under 25	8.4	8.3	9.1	+8.3
25 to 34	37.4	33.1	22.3	−40.4
35 to 44	27.9	24.6	19.5	−30.1
45 to 54	16.9	14.9	17.5	+3.6
55 plus	5.4	4.7	6.1	+13.0
Percent of total 1st admissions:				
All ages	21.0	17.6	15.0	
Under 25	30.9	24.2	19.1	
25 to 34	35.5	27.9	20.0	
35 to 44	29.0	23.1	14.5	
45 to 54	18.6	15.4	16.4	
55 plus	4.3	4.0	6.1	

TABLE 7.—MALE ADMISSIONS WITH NO PRIOR INPATIENT PSYCHIATRIC CARE DIAGNOSED WITH ALCOHOL DISORDERS, SELECTED AGE GROUPS, STATE AND COUNTY MENTAL HOSPITALS, 1962, 1965, AND 1969

Selected age groups	1962	1965	1969	Percent change 1962–69
NUMBER OF FIRST ADMISSIONS				
All ages	16,213	20,528	26,536	+63.7
25 to 34	2,659	3,387	4,248	+59.8
35 to 44	4,974	6,261	7,743	+55.7
45 to 64	7,490	9,361	12,884	+72.0
RATE PER 100,000 POPULATION				
All ages	18.2	22.0	27.6	+51.6
25 to 34	25.8	32.7	37.0	+43.4
35 to 44	42.9	53.9	70.1	+63.4
45 to 64	40.9	49.8	65.3	+59.7
PERCENT OF TOTAL FIRST ADMISSIONS				
All ages	22.3	24.9	26.8	
25 to 34	21.6	23.6	25.9	
35 to 44	38.4	42.4	44.8	
45 to 64	39.1	43.6	47.7	

TABLE 8.—LEADING 3 DIAGNOSES AMONG ADMISSIONS WITH NO PRIOR INPATIENT PSYCHIATRIC CARE, STATE AND COUNTY MENTAL HOSPITALS, 1962 AND 1969[1]

Selected age groups	Males		Females	
	1962	1969	1962	1969
15 to 24	1. Schizophrenia 2. Personality disorders 3. Mental retardation	1. Schizophrenia 2. Personality disorders 3. Drug disorders	1. Schizophrenia 2. Personality disorders 3. Neuroses	1. Neuroses. 2. Schizophrenia. 3. Mental retardation.[2] Personality disorders.
25 to 34	1. Schizophrenia 2. Alcohol disorders 3. Personality disorders	1. Alcohol disorders 2. Schizophrenia 3. Personality disorders	1. Schizophrenia 2. Neuroses 3. Personality disorders	1. Neuroses. 2. Schizophrenia. 3. Personality disorders.[2] Alcohol disorders.
35 to 44	1. Alcohol disorders 2. Schizophrenia 3. Personality disorders	1. Alcohol disorders 2. Schizophrenia 3. Personality disorders	1. Schizophrenia 2. Psychoneurosis 3. Affective disorders	1. Neuroses. 2. Schizophrenia. 3. Alcohol disorders.
45 to 54	1. Alcohol disorders 2. Schizophrenia 3. Personality disorders	1. Alcohol disorders 2. Schizophrenia 3. Personality disorders	1. Schizophrenia 2. Affective disorders 3. Neuroses	1. Alcohol disorders. 2. Schizophrenia. 3. Neuroses.
All ages	1. Alcohol disorders 2. Brain syndromes 3. Schizophrenia	1. Alcohol disorders 2. Brain syndromes (nec) 3. Schizophrenia	1. Organic brain syndromes 2. Schizophrenia 3. Affective disorders	1. Neuroses. 2. Schizophrenia. 3. Organic brain syndromes.

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[1] The listing of leading diagnostic categories is dependent to some extent on the detail used in classifying mental disorders. For example, if one used several subcategories of organic brain syndromes instead of the category total, then the leading 3 diagnoses would be different. In this analysis, the diagnostic groupings used were those 7 categories given above plus "affective disorders" (code 296), and mental retardation (codes 310–315).

[2] Tied for 3d place.

TRENDS IN FIRST ADMISSIONS AND RESIDENT PATIENTS UNDER 18 YEARS OF AGE BY DIAGNOSIS, SELECTED STATES 1966–1968

State trends in first admissions and resident patients in state and county mental hospitals for the period 1966–1968 presented in Statistical Note 14 indicated that the *trend of increasing first admissions to these hospitals was most prevalent among the states in the under 18 year age group with all but eleven states experiencing increases in first admissions in this age group.* Moreover, despite the fact that an overall decline in resident patients was observed for these hospitals during this period, *31 states experienced increases in resident patients under 18 years of age.* The purpose of this Note is to further investigate this age group to determine if these observed increases were concentrated in any particular diagnostic groupings.

Data are presented for the United States and for 14 states in which first admissions and resident patients by age and diagnosis were reported for at least two of the three years shown, and in which the number of patients under 18 years of age was of sufficient size to provide meaningful comparisons among states over time for five major diagnostic groupings.

First admissions under 18 years of age to state and county mental hospitals diagnosed with acute and chronic brain syndromes, personality disorders, transient situational personality disorders, and mental deficiency increased between 1966 and 1968 both nationally and in half or more of the 14 states. (Table 1) Those diagnosed with psychotic disorders showed a slight decline for the United States as a whole and a variable pattern of change among the states.

Resident patients in this age group diagnosed with transient personality disorders and mental deficiency increased in the state and county mental hospitals in the United States between 1966 and 1968, while patients with personality disorders remained relatively unchanged and those with acute and chronic brain syndromes and psychotic disorders declined. (Table 2) Only for the latter diagnosis did more than half of the states reflect the national pattern of decline. Otherwise, the pattern of change among the states for each of the other diagnostic groupings showed considerable variability from the respective national pattern.

TABLE 1.—FIRST ADMISSIONS UNDER 18 YEARS OF AGE, NUMBERS AND RATES PER 100,000 POPULATION, STATE AND COUNTY MENTAL HOSPITALS, BY SELECTED DIAGNOSES, UNITED STATES AND SELECTED STATES, 1966-68

State	Acute and chronic brain syndrome				Phychotic disorders				Personality disorders				Transient situational personality disorders				Mental deficiency			
	1966	1967	1968	Percent change 1966-68	1966	1967	1968	Percent change 1966-68	1966	1967	1968	Percent change 1966-68	1966	1967	1968	Percent change 1966-68	1966	1967	1968	Percent change 1966-68
NUMBER																				
United States	952	898	1,113	16.9	2,569	2,616	2,503	−2.6	2,116	2,194	2,625	24.1	3,639	3,845	4,355	19.7	951	1,104	1,195	25.7
California	65	70	92	40.0	225	195	225	0	271	300	353	30.3	241	259	312	29.5	60	38	27	−55.0
Colorado	16	15	10	−37.5	24	25	24	0	30	50	65	116.7	59	53	65	10.2	5	9	3	−40.0
Georgia	89	70	107	20.2	66	70	68	3.0	12	19	23	91.7	82	110	99	20.7	94	149	156	66.0
Illinois	28	34	45	60.7	68	58	73	7.4	59	74	131	122.0	55	106	173	214.5	26	35	56	115.4
Maryland	27	23	17	−37.0	53	47	22	−58.5	57	65	70	22.8	185	168	137	−25.9	11	23	17	54.5
Missouri	21	21	46	119.0	24	21	43	79.2	47	39	79	68.1	83	94	127	53.0	20	34	23	15.0
New Jersey	28	52	57	103.6	100	109	119	19.0	94	102	90	−4.3	124	132	130	4.8	56	67	63	10.7
New York	111	119	135	21.6	767	766	745	−2.9	119	141	147	23.5	747	762	865	17.4	96	113	117	21.9
Ohio	72	59	70	−2.8	119	124	110	−7.6	136	127	186	36.8	206	234	273	32.5	57	53	55	−3.5
Pennsylvania	22	19	16	−27.3	106	136	64	−39.6	115	123	104	−9.6	78	86	57	−26.9	25	30	17	−23.0
Tennessee	21	20	16	−23.8	59	46	35	−40.7	33	34	85	157.6	60	47	79	31.7	21	16	48	128.6
Texas	24	32	35	45.8	77	89	60	−22.1	57	59	46	−19.3	101	93	150	48.5	28	41	53	89.3
Virginia	55	53	69	25.5	30	19	43	43.3	64	17	35	−46.9	81	63	105	29.6	56	77	44	−21.4
Wisconsin [1]	42	29	19	−54.8	60	59	49	−18.3	104	97	94	−10.5	141	204	181	28.4	15	24	20	33.3
RATE PER 100,000																				
United States	1.4	1.3	1.6	14.3	3.6	3.7	3.5	−2.8	3.0	3.1	3.7	23.3	5.2	5.5	6.2	19.2	1.3	1.6	1.7	30.8
California	1.0	1.0	1.4	40.0	3.4	2.9	3.4	0	4.1	4.5	5.3	29.3	3.6	3.9	4.7	30.6	0.9	0.6	0.4	−55.6
Colorado	2.2	2.0	1.3	−40.9	3.3	3.4	3.2	−3.0	4.1	6.8	8.7	112.2	8.0	7.2	7.8	8.8	.7	1.2	.4	−42.9
Georgia	5.3	4.1	6.3	18.9	3.9	4.1	4.0	2.6	.7	1.1	1.3	85.7	4.8	6.5	5.8	20.8	5.6	8.8	9.1	62.5
Illinois	.7	.9	1.2	71.4	1.8	1.5	1.9	5.6	1.6	1.9	3.4	112.5	1.4	2.8	4.5	221.4	.7	.9	1.5	114.3
Maryland	2.0	1.7	1.3	−35.0	4.0	3.5	1.6	−60.0	4.3	4.8	5.2	20.9	13.9	12.5	10.1	−27.3	.8	1.7	1.3	62.5
Missouri	1.3	1.3	2.9	123.1	1.5	1.3	2.7	80.0	3.0	2.5	5.0	66.7	5.3	6.0	8.1	52.8	1.3	2.2	1.5	15.4
New Jersey	1.2	2.2	2.4	100.0	4.3	4.6	5.0	16.3	4.0	4.3	3.8	−5.0	5.3	5.6	5.5	3.8	2.4	2.9	2.6	8.3
New York	1.9	2.0	2.3	21.1	12.8	12.8	12.5	−2.3	2.0	2.4	2.5	25.0	12.3	12.8	14.5	17.9	1.6	1.7	2.0	25.0
Ohio	1.9	1.6	1.8	−5.3	3.1	3.3	2.9	−6.5	3.6	3.3	4.9	36.1	5.4	6.1	7.2	33.3	1.5	1.4	1.4	6.7
Pennsylvania	.6	.5	.4	−33.3	2.7	3.5	1.6	−40.7	2.9	3.1	2.7	−6.9	2.0	2.2	1.5	−25.0	.6	.5	.4	−33.3
Tennessee	1.5	1.4	1.2	−20.0	4.3	3.3	2.5	−41.9	2.4	2.5	6.2	158.3	4.3	3.4	5.7	32.6	1.5	1.2	3.5	−133.3
Texas	.5	.8	.9	50.0	1.9	2.2	1.5	−21.1	1.4	1.4	1.1	−21.4	2.5	2.3	3.7	48.0	.7	1.0	1.3	85.7
Virginia	3.4	3.2	4.2	23.5	1.8	1.2	2.6	44.4	3.9	1.0	2.1	−46.2	5.0	3.9	6.4	28.0	3.4	4.7	2.7	−20.6
Wisconsin [1]	2.7	1.9	1.2	−55.6	3.9	3.8	3.2	−17.9	6.7	6.2	6.2	9.0	9.1	13.1	11.7	28.6	1.0	1.5	1.3	30.0

[1] Data for 1966 are estimates since Wisconsin did not report first admissions by age by diagnosis in this year.

TABLE 2.—RESIDENT PATIENTS UNDER 18 YEARS OF AGE, NUMBERS AND RATES PER 100,000 POPULATION, STATE AND COUNTY MENTAL HOSPITALS, BY SELECTED DIAGNOSIS, UNITED STATES AND SELECTED STATES, 1966-68

State	Acute and chronic brain syndrome				Psychotic disorders				Personality disorders				Transient situational personality disorders				Mental deficiency			
	1966	1967	1968	Percent change, 1966-68	1966	1967	1968	Percent change, 1966-68	1966	1967	1968	Percent change, 1966-68	1966	1967	1968	Percent change, 1966-68	1966	1967	1968	Percent change 1966-68
NUMBER																				
United States	1,801	1,740	1,683	−6.6	3,802	3,682	3,435	−9.7	1,166	1,095	1,164	−0.2	2,563	2,685	2,776	8.3	1,461	1,566	1,710	17.0
California	99	89	78	−21.2	343	341	329	−4.1	145	150	144	−.7	93	76	109	17.2	46	33	34	−26.1
Colorado	11	25	11	0	39	25	24	−38.5	35	36	44	25.7	16	27	39	143.8	21	23	5	−76.2
Georgia	138	136	172	24.6	63	64	60	−4.8	4	7	5	25.0	43	74	77	65.1	127	205	260	104.7
Illinois	61	61	74	21.3	118	99	128	8.5	79	70	79	0	64	61	100	56.2	88	85	90	2.3
Maryland	22	19	16	−27.3	36	36	29	−19.4	29	37	36	24.1	136	135	103	−24.3	11	14	13	18.2
Missouri	36	31	34	−5.6	41	47	58	41.5	32	22	31	−3.1	76	52	78	2.6	19	23	49	157.9
New Jersey	95	102	94	−1.1	193	187	179	−7.3	64	49	47	−26.6	114	118	110	−3.5	105	101	86	−18.1
New York	180	196	223	23.9	1,185	1,155	1,116	−5.8	28	32	62	121.4	943	942	964	2.2	181	187	217	19.9
Ohio	85	86	81	−4.7	132	119	115	−12.9	82	73	83	1.2	105	140	145	38.1	27	28	35	29.6
Pennsylvania	57	54	45	−21.1	226	264	227	.4	107	118	103	−3.7	91	99	65	−28.6	26	26	25	−3.8
Tennessee	23	21	24	4.3	42	39	30	−28.6	9	6	45	400.0	18	26	25	38.9	11	18	38	245.5
Texas	77	26	31	−59.7	228	53	47	−79.4	27	24	26	−3.7	49	54	70	42.9	95	56	52	−45.3
Virginia	268	259	260	−3.0	68	65	65	−4.4	17	11	11	−35.3	40	20	20	−50.0	86	122	122	41.9
Wisconsin [1]	39	34	20	−48.7	84	84	79	−6.0	33	33	38	15.2	69	102	89	29.0	16	17	22	37.5
RATE PER 100,000																				
United States	2.6	2.5	2.4	−7.7	5.4	5.2	4.9	−9.3	1.7	1.5	1.6	−5.9	3.6	3.8	3.9	8.3	2.1	2.2	2.4	14.8
California	1.5	1.3	1.2	−20.0	5.1	5.1	4.9	−3.9	2.2	2.2	2.1	−4.5	1.4	1.1	1.6	14.3	.7	.5	.5	−28.6
Colorado	1.5	3.4	1.5	0	5.3	3.4	3.2	−39.6	4.8	4.9	5.9	22.9	2.2	3.6	5.2	136.4	2.9	3.1	.7	−75.7
Georgia	8.1	8.0	10.1	24.7	3.7	3.8	3.5	−5.4	.2	.4	.3	50.0	2.5	4.4	4.2	68.0	7.5	12.1	15.2	102.0
Illinois	1.6	1.6	1.9	18.8	3.1	2.6	3.3	6.5	2.1	1.8	2.0	−4.8	1.7	1.6	2.6	52.9	2.3	2.2	2.3	0
Maryland	1.6	1.4	1.2	−25.0	2.7	2.7	2.1	−22.2	2.2	2.7	2.6	18.2	10.2	10.0	7.6	−25.5	.8	1.0	1.0	25.3
Missouri	2.3	2.0	2.2	−4.3	2.6	3.0	3.7	42.3	2.0	1.4	2.0	0	4.8	3.3	5.0	4.2	1.2	1.5	3.1	158.0
New Jersey	4.1	4.3	4.0	−2.4	8.2	7.9	7.6	−7.3	2.7	2.1	2.0	−25.9	4.9	5.0	4.6	−6.1	4.5	4.3	3.6	−20.0
New York	3.0	3.3	3.7	23.3	19.7	19.4	18.7	−5.1	.5	.5	1.0	100.0	15.7	15.9	16.1	2.5	3.0	3.1	3.6	20.6
Ohio	2.2	2.3	2.1	−4.5	3.5	3.1	3.0	−14.3	2.2	1.9	2.2	0	2.8	3.7	3.8	35.7	.7	.7	.9	28.3
Pennsylvania	1.5	1.4	1.2	−20.0	5.8	6.8	5.8	0	2.7	3.0	2.7	0	2.3	2.5	1.7	−26.1	.7	.7	.6	−14.0
Tennessee	1.7	1.5	1.7	0	3.0	2.8	2.2	−26.7	.7	.4	3.3	371.4	1.3	1.9	1.8	38.5	.8	1.3	2.8	250.5
Texas	1.9	.6	.8	−57.9	5.6	1.3	1.1	−80.4	.7	.6	.6	−14.3	1.2	1.3	1.7	41.7	2.3	1.4	1.3	−43.6
Virginia	16.4	15.8	15.8	−3.7	4.2	4.0	4.0	−4.8	1.0	.7	.7	−30.0	2.5	1.2	1.2	−52.0	5.3	7.5	7.4	39.0
Wisconsin [1]	2.5	2.2	1.3	−48.0	5.4	5.4	5.1	−5.6	2.1	2.1	2.5	19.0	4.4	6.6	5.8	31.8	1.0	1.1	1.4	40.9

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[1] Data for 1966 are estimates since Wisconsin did not report resident patients by age, by diagnosis in this year.

"UTILIZATION OF PSYCHIATRIC FACILITIES BY CHILDREN"—PUBLIC HEALTH SERVICE PUBLICATION NO. 1868 PRINTED 1968

INTRODUCTION

During the last two decades, significant changes have occurred in the administration of mental health programs on local, State, and national levels and in the development of treatment and rehabilitation methods. Administrative changes were largely supported by Federal legislation which includes: the National Mental Health Act, resulting in a rapid growth in outpatient psychiatric clinics and the concurrent establishment of inpatient psychiatric services in a number of general hospitals (1); the 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act, providing construction funds for community-based mental health facilities to include inpatient, outpatient, day care and emergency services, and the 1965 legislation, providing funds for staffing these centers (2, 3); and most recently, the Social Security Amendments of 1965 (PL 89-97) providing funds for care and treatment of the elderly mentally ill and for research grants for mental and emotional illness in children (4).

While legislation fostered the development of a variety of mental health facilities, treatment methods changed radically with the introduction of tranquilizers and other psychoactive drugs. As a result, many patients in long-term mental hospitals, previously doomed to aging and dying in an institution, were able to return to the community where the increased availability of outpatient community resources, followup care, and related social services made it possible to maintain many such patients in the community. The availability of nursing homes and other resources providing services similar to those in a mental hospital also made it possible to prevent admission to the mental hospital of certain kinds of patients, for example, those with diseases of the senium or chronic schizophrenia.

Although most Federal legislation focused on general mental health care, the need for specific services for children was recognized. This resulted in the establishment of the Joint Commission on Mental Health of Children through a grant by the National Institute of Mental Health from funds provided by the Social Security Amendments of 1965. The purpose of this group has been to develop "a program of research into and study of our resources, methods, and procedures for diagnosing and preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illness" in order "to develop a body of knowledge and a set of recommendations representing the very best this country has to offer to strengthen the mental health of its children" (5). This report was stimulated by and prepared for the Commission to assist them in carrying out this responsibility.

While not specifically oriented toward the mental health of children, the National Institute of Mental Health, nevertheless, has allocated a large part of its grants for research, demonstration projects, and training toward primary prevention and treatment of childhood mental illness, and a large segment of its intramural programs has been oriented toward this end. The Institute also has played a major role in promoting legislation and in administering the funds provided by such legislation.

This report, describing the utilization of psychiatric facilities by children, serves as a backdrop to both the National Institute of Mental Health child program and the work of the Joint Commission on Mental Health of Children. Included are extensive data on patterns of care by age, sex, diagnostic, and other characteristics of children under 18 years of age served in the following types of psychiatric facilities in the United States: outpatient psychiatric clinics, State and county mental hospitals, private mental hospitals, and psychiatric services in general hospitals. Knowledge of the utilization patterns of these facilities is particularly important in planning and administering the rapidly expanding and developing mental health programs throughout the nation.

Only limited information on children served in psychiatric day-night facilities, residential treatment centers other than those operated by State mental hospitals, or treated in private psychiatric practice, is available. In spite of the paucity of information for the latter facilities, however, sufficient information is available to permit an estimate of the number of children receiving services in psychiatric facilities in the United States during a year. Data presented are obtained from the annual nationwide reporting programs and special studies conducted by the Biometry Branch, National Institute of Mental Health (6, 7, 8).

TOTAL NUMBER OF CHILDREN SERVED IN PSYCHIATRIC FACILITIES IN THE UNITED STATES

About 473,000 children under 18 years of age received some service in a psychiatric facility in the United States in 1966 (table 1). Of these children, 84 percent were seen on an outpatient basis and 14 percent were hospitalized. Of the latter, 27,400 were patients in public mental hospitals, and 28,000 in general hospitals.

Children comprised 34 percent of the total caseload of outpatient psychiatric clinics. In contrast, 3 to 8 percent of the caseloads of inpatient facilities consisted of persons under 18 years of age. Of the three types of hospitals, State and county mental hospitals had the smallest proportion of children.

Table 1

Number of Psychiatric Facilities and Estimated Number of Children under 18 Years of Age under Care during the Year in Each Type of Facility, 1966

Type of facility	Facilities		Total patients -- all ages		Children under 18 years of age		
	Number	Percent distribution	Estimated number	Percent distribution	Estimated number	Percent distribution	Percent of total patients in each type of facility
		(%)		(%)		(%)	(%)
Outpatient psychiatric clinics 1/	2,122	56	1,186,000	46	399,000	84	34
State and county mental hospitals	297	8	807,000	31	27,400	6	3
Private mental hospitals	175	5	105,000	4	8,400	2	8
General hospitals with psychiatric services	888	23	466,000	18	28,000	6	6
Psychiatric day-night units 2/	173	5	15,600	1	2,500	1	16
Residential treatment centers (not in state mental hospitals) 3/	149	4	---	---	8,000	2	---
Total	3,804	100	2,579,600	100	473,300	100	18

1/ Includes clinics of the Veterans Administration.

2/ Based on survey conducted in 1965 providing estimated number of children served in 1964. Includes day-night units of the Veterans Administration.

3/ Based on the average capacity or average number of residents reported for 92 facilities.

Source: Directory of Facilities for Mentally Ill Children in the United States, 1967, The National Association for Mental Health, Inc.
The Directory for Exceptional Children, F. Porter Sargent, Fifth Edition, 1965.

UTILIZATION OF SPECIFIC FACILITIES

OUTPATIENT PSYCHIATRIC CLINICS

Number of Patients and Patient Movement

The number of children under 18 years of age receiving care in clinics has almost doubled since 1959, from 208,000 to 399,000 in 1966 (9, 10) (tables 2a, 2b; figure 1a). The growth in the patient caseload was only partly due to the increase in the child population in the United States. Even if we account for the general population growth, the greater demand for and availability of these services resulted in a 70 percent increase in usage rates (per 100,000 population) between 1959 and 1966 (figure 1b). The numbers of patients under care during this period increased more rapidly than either the number of clinics or the professional man-hours available (11).

Of the children under care during 1966, about 52 percent were new admissions to the clinic of application, and an additional 5 percent were readmissions who had been under care in the clinic in a previous year. The remaining 43 percent had been on the clinic rolls from the preceding year.

An estimated 216,000 children, or 54 percent of the caseload, were terminated from clinic services in 1966 (figures 2a, 2b). The proportion terminated has decreased slightly each year during the past few years (60 percent in 1959) resulting in a larger proportion of patients being "carried over" at the beginning of each year.

Most of the data on clinic patient characteristics and services received, discussed in this report, are based on information on patients for whom services were terminated. Because of the short duration of clinic service, data on terminations are considered a good approximation of admissions (12).

Age and Sex

The adolescent group, age 10-17 years, comprised two-thirds of the children served and, in fact, for boys was the largest group of patients of any comparable age span (10 year age group) in the clinic population (figures 1a, 1b). Children 5 to 9 years accounted for an additional third of the patients under 18 years. Unlike the pattern of increased usage by children of school age during the last decade, pre-schoolers accounted for only 6 percent of the clinic child population and have shown little change in the extent of clinic usage in the last few years. Rates of clinic utilization for children peaked at 9 and 10 years for younger children and about 14 or 15 years of age for adolescents (13, 14) (figure 3).

Twice as many boys as girls were given service in clinics (tables 2a, 2b). This was generally true for all ages under 18 years. Little variation in this sex ratio, from year to year, has been noted. However, at 18 and 19 years of age, the rates for boys dropped sharply to nearly half the 10-17 level (from about 300 terminations, per 100,000 population, to approximately 170). This drop not only reflects discontinued contact with the public schools, one of the major case-finding agencies for children, but also the lack of other major community programs which may serve as case-finding and referral agencies for young adults.

Diagnostic Characteristics

Thirty-four percent of the children who were terminated from clinic service received a diagnosis of transient situational personality disorder (table 3a; figure 4a) while 25 percent were "undiagnosed." The large proportion of children not receiving a diagnosis reflects, to a large extent, the brief contact that many children have with a clinic. In terms of other reported diagnoses, among the very young children (under 5 years of age), brain syndromes and mental deficiency accounted for almost half (table 3a). Personality disorders, particularly passive aggressive personality disorder, assumed considerable importance among older children, especially among the boys (figures 4b, 4c).

Certain service factors affect the completeness of the diagnostic data. Only 6 percent of the children receiving treatment services were "undiagnosed" while a third of the nontreated group were reported in this category. The intake practices or policies regarding certain diagnostic groups may also influence the prevalence of certain disorders in clinics. For example, a recent study indicated that only two-thirds of the clinics serving children accept mental retardates (15).

Color

Current data by color are not available. However, data obtained from a special study for 1961 may still be representative of current utilization patterns (14). The principal differences by color were the lower rates for nonwhites than whites among the younger children (under 11 years of age) in contrast to the higher rates for adolescents (figure 5). This pattern was consistent for both boys and girls. Further, nonwhite rates were higher than whites of the same sex for all children with mental deficiency and for adolescents with psychotic disorders (figure 6).

It should be noted that these data by color were more completely reported by clinics in the South and may not be representative of the United States as a whole.

Referral Source

Data on the source of referral, that is, the individual or type of agency recommending that the patient apply for clinic service, indicate that three groups were most responsible for recommending clinic services for children: the physician or other community health agency (26 percent), the school (24 percent), and the family or friends (20 percent) (16). Younger children were referred most frequently by physicians or their families, older children most frequently by schools (17, 13). Among the adolescents, a larger proportion of boys than girls were referred by schools and courts while more girls than boys were referred by private physicians, social service agencies, or their families (figure 7).

Type of Service

One-third of the children received treatment services while two-thirds received nontreatment services. For reporting purposes, treatment services are defined as "a service usually initiated by clinic plan following application and diagnosis (explicit and implicit) designed to reduce some amount of the patient's symptomatology" (7). Nontreatment services usually consist of intake services and referral to other agencies, and evaluation and psychological testing, frequently for other agencies and particularly for schools in rural areas.

A variety of factors influence the provision of treatment in a clinic, such as the patient's age, sex, diagnosis, and the referral source. For example, in the adolescent group, fewer of those 14 and 15 years of age but more of the 18 and 19 year olds were treated. Almost half of the adolescents with psychoneurotic, psychotic, and personality disorders received treatment services; however, only slightly more than a third of those with brain syndromes and very few patients with mental deficiency (12 percent) received this service (figure 8). Regardless of age or diagnosis, more girls were treated than boys.

The source of referral of patients also influenced the probability of treatment. Children referred by mental hospitals, probably for aftercare services, were more frequently treated than those referred by most other agencies. Those referred by training schools for the mentally retarded rarely received treatment (figure 9).

Amount of Service

One method used to evaluate the amount of service provided to children in outpatient clinics is a count of the number of person-interviews received. Children who did not receive treatment services had a median of three interviews; those receiving treatment, a median of 16 interviews. In examining the data for adolescents, we see that the median number of interviews was considerably higher for the younger adolescents than for the older ones (figure 10), and higher for boys than girls except for the oldest group. The larger number of interviews for the younger patients reflects, in part, the greater involvement of parents or collaterals in services for the younger child, since each person present at an interview is counted. Data from table 4 show that considerably more of the older adolescents were interviewed without their parents or collaterals than were the younger ones.

Disposition

Information is reported on the disposition of the clinic case after termination—that is, whether the patient withdrew on his own, the clinic closed the case because further care was not needed, or the clinic referred the patient to another community organization for further service and, if so, to which type of agency.

According to the 1963 special clinic study, 28 percent of the children under 18 years of age "dropped out" of clinic service, 33 percent were terminated because further care was not indicated or for other reasons, and 39 percent were referred to other agencies for further care (16).

Patient characteristics and referral source, as well as clinic service, appear to influence the outcome of service (appendix tables 1-4). For example, in terms of age, older adolescents (16-19 years) showed a greater tendency to withdraw from service than younger ones, regardless of whether they were seen in the clinic for treatment or for other services; or they were more likely to be referred to another psychiatric facility after receiving clinic services. The younger patients (12-15 years), on the other hand, were more often referred to a community agency for further care, probably to the original referring agencies. Regarding diagnosis, children with the more serious psychiatric disorders such as brain syndromes, mental deficiency, and psychosis were most likely to be referred elsewhere for further care and least likely to withdraw from service on their own.

Data on referral source and disposition clearly indicate that the clinic is frequently used as an evaluating service only. Patients who were referred by community agencies such as schools, social agencies, and courts were generally referred back to the same type of agency. This pattern was not necessarily consistent for patients sent to the clinic by their families. These patients more frequently withdrew from clinic services than those referred by community agencies. If they were referred elsewhere subsequent to clinic care, the referral was more frequently to private psychiatrists and other outpatient psychiatric resources than to any other community agency.

Treated patients were more likely to be discharged by the clinic with "no further care indicated" and less likely to be referred to other agencies for additional services.

Staffing Patterns

Data on staffing patterns specifically for children's clinics are not readily available for 1965 or 1966. However, trends in staffing patterns, in 1965, for all clinics can be examined to provide information on availability of clinic resources.

Clinics generally employ a "core" mental health team consisting of at least a psychiatrist, psychologist, and social worker. Some also employ other professionals such as nurses, physicians, speech therapists, etc. In 1965, the mental health team provided 221 professional man-hours per week per 100,000 population, according to a nationwide survey conducted the week of April 30, 1965 (9).

Less than a third of the regular clinic staff worked full-time. Excluding trainees, only 13 percent of the psychiatrists, 36 percent of the psychologists, and 54 percent of the social workers worked full-time. Nevertheless, in terms of man-hours, the psychiatrist provided 31 percent of the clinic professional man-hours, the psychologist 21 percent, and the social worker 38 percent. A variety of other mental health professionals supplied the remaining 10 percent.

The amount of time devoted by the psychiatrist, psychologist, and social worker, shows considerably smaller increases (approximately 8 percent from 1963 to 1965, respectively) than that by other professionals (39 percent).

Considering that between 1963 and 1965 the increase in the professional man-hours rate (per 100,000 persons) was only 14 percent, and in the number of patients per 100,000 population 21 percent, demands for service are increasing at a considerably more rapid rate than our ability to fulfill them.

Geographic Distribution

The variation in the geographic distribution of clinics is shown in table 5. In 1966, half the States had less than 25 clinics; only one-fifth had 50 or more. According to the 1965 survey, the ratio of professional weekly man-hours for individual States ranged from 758 per 100,000 population to 23 (table 6). The average number of man-hours per 100,000 population was 221. the median 137. Only 10 States provided at least 280 man-hours per 100,000 population or sufficient man-hours for two full clinic teams.

Fifteen States reported less than 100 man-hours. In general, the States with the most clinics provided relatively greater numbers of man-hours per 100,000 population. As a result, the average number of man-hours was heavily weighted by man-hours contributed by these States.

A special study on the availability of clinics in areas designated rural in the 1960 census, was conducted for 1965. A rural area, for this study, was defined as one located in a county in which 50 percent or more of the population lived in towns of less than 2,500 persons and where the county is not in a standard metropolitan statistical area. This study was considered particularly pertinent because, in rural areas, the psychiatric clinic is frequently the only mental health resource available to children. In urban and suburban areas, on the other hand, there are a variety of other social agencies such as family service and welfare agencies and psychological testing services of schools.

Although there has been a marked increase in clinics nationwide, rural resources continued to remain sparse. Of the 2,007 clinics open on April 30, 1965, only 234 clinics located in rural areas served children (18). A total of 25,000 children were served in these clinics in 1965, only 8 percent of all children under clinic care in the total United States (table 7) though, according to the 1960 census, one-third of all children lived in rural areas.

The shortage of services in rural areas is apparent in several aspects of clinic service: hours clinics are open, professional man-hours available, and types of services provided. For example, only slightly more than half of the rural clinics were open full-time as compared to almost three-quarters of the clinics nationwide. Only 5 percent of the professional man-hours available in clinics during the reporting week of April 30 were provided in rural clinics. The full orthopsychiatric team of psychiatrist, psychologist, and social worker, was present in only 60 percent of the rural clinics in contrast to about 80 percent of the large urban clinics. Furthermore, services tended to be brief and consisted frequently of psychological testing, thus reflecting the lack of such services in schools and other community agencies in these areas. This shortage of services may reflect problems in staffing, the large proportion of time devoted to travel and limited demand for service. It must be kept in mind, also, that clinics located in urban areas may serve the surrounding rural population. Data on the number of rural residents seen in urban facilities are not available on a nationwide basis.

STATE AND COUNTY MENTAL HOSPITALS

Current Utilization Patterns: Age, Sex, Diagnosis

In 1966 about 27,400 children were under care in the 298 State or county mental hospitals in the United States. Among the reported 10,000 first admissions, 57 percent of the children were 15-17 years of age, 32 percent 10-14 years of age, and 11 percent under 10 years of age (19) (table 3b). The age distributions for first admissions and resident patients were similar, with a slightly higher proportion of children 15-17 years among the first admissions. As was noted for clinic patients, boys outnumbered girls 2 to 1 among first admissions. Boys apparently remain in the hospital longer since relatively more were resident at the end of the year than were admitted during the year.

Schizophrenic reactions and transient situational personality disorders were predominant in each age group (figures 4a, 4b, 4c). Schizophrenia accounted for about 20 percent of the first admissions and 30 percent of the resident patients, while transient situational personality disorders comprised 30 percent of the first admissions and 20 percent of the resident patients. Brain syndromes were also relatively important among children under 10 years (18 percent of the first admissions and 27 percent of the resident patients).

Data on the proportion of patients with certain disorders who are admitted during the year, compared with the proportion who are resident on a specific day, provide indicators, under certain conditions, of duration of care required for certain diseases. Reported data show that patients with schizophrenia, brain syndromes, and mental deficiency are hospitalized for longer periods than those with psychoneurotic, personality, and transient situational personality disorders.

Trends

Until 1966, trend data on children served in these hospitals have been limited because only age breakdowns for "under 15 years" and "15-24 years" have been available (appendix tables 5-10).

Both first admission and resident patient rates among those under 15 years doubled during the last decade. Rates for boys increased at a somewhat more rapid rate than those for girls (figures 11, 12).

A comparison of trends in rates for other age groups with those of children shows that among first admissions increases have been noted for age groups 15-24 years and 25-34 years, although they are less marked than the increases shown for those under 15 years. The rates for all other age groups have remained relatively stable or decreased. Similarly, for resident patients, rates for all age groups 15 years and over either remained relatively stable or showed a decline while those for children under 15 years increased.

Data on factors affecting the admission of children to hospitals are extremely limited. Admission rates are dependent on the availability of inpatient beds for children, adequate hospital programs specifically for children, and family acceptance of hospitalization. Availability of suitable outpatient programs for seriously disturbed children and adequate living arrangements in the community may also affect hospitalization of children.

Geographic Distribution

The distribution of public mental hospitals by State is shown in table 5. Only nine States had 10 or more State and county mental hospitals. Wisconsin had 42, most of which were county hospitals. Considerable variation is noted in the percent of children under 15 who were first admitted to State and county mental hospitals in 1965 (19). For example, 8 percent of all first admissions in Missouri were under 15 years while no children under 15 years were admitted to Maine hospitals.

PRIVATE MENTAL HOSPITALS

Current Utilization Patterns: Age, Sex, Diagnosis

About 8,000 children were served in the 174[1] known private mental hospitals in 1966. Very few children under 10 years (5 percent of the total number of children under 18 years of age) received care in these hospitals (table 3c). In contrast to State mental hospitals, the number of first admissions of boys was only slightly higher than that of girls. Three-quarters of the first admissions 10-17 years of age had psychotic disorders (25 percent), personality disorders (21 percent), and transient situational disorders (27 percent) (figures 4a, 4b, 4c). The specific disorders of importance among this group were schizophrenic reactions (19 percent), personality trait disturbance (8 percent), and psychoneurotic depressive reactions for girls (11 percent). Unlike the public mental hospitals, but similar to general hospitals, private mental hospitals admitted a relatively large proportion of children diagnosed with psychoneurotic disorders (17 percent in private mental hospitals compared with 3 percent in State mental hospitals).

Considerably more boys were resident patients than girls, indicating that boys remained under care for longer periods. Only 1 percent of the resident patients under 18 years was under 5 years of age. Of the relatively few children 5-9 years of age resident at the end of 1966 (6 percent of the children), three types of disorders predominated–brain syndromes (35 percent), personality disorders among boys (30 percent), and schizophrenic reactions among girls (28 percent). Schizophrenic reactions (20 percent), and personality disorders (26 percent), were the most frequent diagnoses among adolescent residents.

Unlike the pattern seen in other psychiatric facilities in which more girls than boys were reported with psychoneurotic disorders, slightly more boys than girls among the resident patients were thus diagnosed. Children with psychoneurosis were in the hospital for short periods of time, however, since the percent with these disorders was considerably smaller among the resident patients (10 percent) than the first admissions (17 percent).

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[1] During the year 1965, the universe of known private mental hospitals was reviewed by the Biometry Branch, NIMH, in conjunction with the State mental health authorities and the National Association of Private Psychiatric Hospitals. In this review it was found that of the 238 hospitals classified as private mental hospitals for 1965 and preceding years, 64 were in fact hospitals for alcoholics, geriatric hospitals, or nursing homes, or for some other reason should not be considered private mental hospitals. The apparent drop in the number of hospitals in operation in 1966 is due, therefore, to a more careful classification of facilities, rather than a change in the number of hospitals.

Trends

Trend data on first admission rates of children to private mental hospitals are available only for age groups under 15 years and 15-24 years of age. For children under 15 years of age, patterns are similar to those of the State and county mental hospitals (20) (appendix tables 11-13). During the last 15 years, rates tripled for those under 15 years (1.3 per 100,000 population in 1965), and showed moderate increases for those 15-24 years (22.4 per 100,000 population in 1965). Rates for other age groups decreased or remained relatively stable. In contrast to the marked differences in rates for boys and girls and young adults (15-24 years) in public mental hospitals, the rates for boys under 15 years (1.4) were only slightly higher than for girls (1.2), while the rates for girls (25.0) were higher than boys (19.6) in the 15-24 year old group.

Geographic Distribution

The 174[2] known private mental hospitals in the United States in 1966 were located in only 36 States (table 5). California, with 25, had the largest number while 30 States had less than 10 each.

INPATIENT PSYCHIATRIC SERVICES OF GENERAL HOSPITALS

Data on discharges by age, sex and diagnosis are collected from inpatient psychiatric services in general hospitals. These data provide a good estimate of admissions because of the short duration of stay in a general hospital. About 28,000 children under 18 years of age received psychiatric inpatient care in the 888 general hospitals in 1966.

Similar to the utilization patterns in other facilities, more boys under 9 years received care than girls. Among older children (10-17 years), however, considerably more girls were served (table 3b).

Very young children (under 5 years of age) comprised 14 percent of the children under 18 years of age discharged from general hospitals; those 5-9 years, 10 percent; young adolescents (10-14 years), another 24 percent; and older adolescents 52 percent. Of the children under 5 years, 66 percent were reported with brain syndromes, and 14 percent with mental deficiency. Of the brain syndrome group, convulsive disorders were responsible for 54 percent, and drug or poison intoxication for another 25 percent. Among the few 5 to 9 year olds, convulsive disorders (17 percent) and mental deficiency (14 percent) were among the predominant diagnoses, and transient situational personality disorder occurred more frequently (17 percent) among the younger children. Schizophrenic reactions, accounting for 14 percent, psychoneurotic disorders and transient situational personality disorders, 21 percent each, were the most important diagnoses for the 10 to 14 year olds.

Of those 15 to 17 years of age, 17 percent had schizophrenic reactions and 27 percent psychoneurotic disorders, particularly psychoneurotic depressive reactions (11 percent). Unlike findings for other facilities, personality disorders were not as important among boys as were the psychoneurotic disorders. Transient situational personality disorders (20 percent) were a major cause for hospitalization in this age group.

Since no data on children are available for previous years, trends will not be discussed. It is noteworthy to mention, however, that 25 years ago only 48 general hospitals admitted psychiatric patients (21), while in 1966, 888 did so.

PSYCHIATRIC DAY-NIGHT SERVICES

Information on psychiatric day-night services in the United States has been collected since 1963. For NIMH reporting purposes, these services are defined as "services having an organized staff whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities. The service is designed for patients with mental or emotional disorders or mental retardation who spend only part of a 24-hour period in the program" (22).

A total of 173 units in the United States reported to the NIMH as of February 1965. Of these, only 72 were open to children under 12 years of age, and 120 were open to children 12 to 17 years. Of the 16,000 patients served during the year, 2,500 or 16 percent were children. Twelve hundred were under 12 years, and 1,300, 12 to 17 years of age. All facilities serving only children provided educational therapy. Between 80 to 90 percent provided individual, family, group, and recreational therapies (table 8).

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[2] See footnote page 8

Most of the children's facilities reported full-time attendance (5 days a week) by their patients, a reflection of the educational characteristics of children's day care facilities.

A rapid growth is expected in the number of day-night units, particularly as they become integrated into community mental health centers. Information on the characteristics of patients served in these units is not yet available but will be in the near future.

PRIVATE PSYCHIATRIC PRACTICE

Very little data are available on the number and characteristics of patients served in private psychiatric practice. A sample survey of characteristics of patients treated by private psychiatrists indicated that 4 percent of the approximately 750,000 patients seen in private practice, or 30,000 children under 15 years, received these services annually (23) (figure 13). Another study of a prepaid group medical practice showed that children under 15 years of age referred for psychiatric service comprised a considerably lower proportion of private psychiatric service (0.4 percent) (24). Data from the Monroe County, N.Y., psychiatric case register indicated that about 3 percent of the private practitioner caseload consisted of children under 15 (25). Such findings tend to corroborate the impression that relatively few children receive private psychiatric care.

COMMUNITY MENTAL HEALTH CENTERS

The development of the Community Mental Health Center program is too recent to measure its impact on the treatment of children. However, a recent survey conducted by the Biometry Branch indicated that 114 out of 133 reporting facilities served approximately 1,400 children under 18 years of age, or 20 percent of the 7,100 patients under care in such centers during a 1-day period in November 1967. This proportion of children falls between the 34 percent under care in outpatient clinics and the 8 percent or less in inpatient facilities.

Two-thirds of the children served in centers were boys. Of those children under 12 years, boys outnumbered girls 3 to 1, but the ratio was 3 to 2 for 12 to 17 year olds. Most children were outpatients and the largest proportion was diagnosed as having transient situational personality disorders. The most frequently used treatment methods were individual, group, and recreational therapies.

Table 2a

Estimated Number of Patients under Care and Terminations during the Year, Outpatient Psychiatric Clinics, United States, 1959-1966

Year	Patients under care				Terminations			
	Total all ages	Total under 18 years	Under 10 years	10-17 years	Total all ages	Total under 18 years	Under 10 years	10-17 years
	(numbers in thousands)							
Both sexes								
1959	502	208	86	122	283	125	53	72
1960	578	238	96	142	313	137	55	82
1961	669	241	97	144	349	138	55	83
1962	741	270	105	165	384	154	61	93
1963	862	295	112	183	453	164	63	101
1964	993	330	127	203	523	182	70	112
1965	1,085	384	145	239	543	210	79	131
1966 1/	1,186	399			593	216		
Males								
1959	305	138	58	80	167	83	35	48
1960	347	158	64	94	183	91	37	54
1961	386	160	65	95	197	92	37	55
1962	425	180	72	108	215	102	41	61
1963	488	195	77	118	248	109	43	66
1964	544	217	87	130	277	120	48	72
1965	605	255	100	155	294	140	55	85
Females								
1959	197	70	28	42	116	42	18	24
1960	231	80	32	48	130	46	18	28
1961	283	81	32	49	152	46	18	28
1962	316	90	33	57	169	52	20	32
1963	374	100	35	65	205	55	20	35
1964	449	113	40	73	246	62	22	40
1965	480	129	45	84	249	70	24	46

1/ Excludes Puerto Rico and Virgin Islands.

Source: Outpatient Psychiatric Clinics - Annual Statistical Report, Data on Patients, 1959-1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

Provisional Patient Movement Data, Outpatient Psychiatric Clinics, United States, 1966. Mental Health Statistics, Current Facility Reports, Series MHB-J-1, January 1967. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

Table 2b

Estimated Number of Patients under Care and Terminations during the Year, Rates per 100,000 Population 1/, Outpatient Psychiatric Clinics, United States, 1959-1965

Year	Patients under care				Terminations			
	Total all ages	Total under 18 years	Under 10 years	10-17 years	Total all ages	Total under 18 years	Under 10 years	10-17 years
Both sexes								
1959	286.0	327.0	224.0	493.0	161.9	197.0	135.8	292.7
1960	317.8	364.2	242.3	552.7	172.2	209.6	139.6	317.8
1961	368.3	369.2	244.4	562.3	192.3	211.6	139.9	322.3
1962	403.6	402.9	259.7	622.5	209.4	229.8	149.6	352.8
1963	462.7	430.0	274.3	664.0	243.1	239.4	153.2	368.9
1964	525.2	471.8	307.6	711.0	276.5	260.6	170.0	392.6
1965	561.6	538.1	347.4	805.1	281.1	294.0	189.8	439.7
Males								
1959	356.0	427.0	292.0	639.0	196.3	257.1	177.8	381.3
1960	387.5	476.4	317.0	723.4	204.0	273.9	182.6	415.4
1961	431.5	482.6	324.2	728.1	219.9	276.5	185.7	417.4
1962	474.8	529.1	347.8	807.9	240.9	301.8	199.7	458.8
1963	539.0	560.9	370.4	848.0	273.4	312.5	206.9	471.5
1964	591.3	610.0	413.0	897.9	301.6	336.9	228.1	495.9
1965	644.4	703.9	472.0	1029.4	312.8	384.5	258.1	562.0
Females								
1959	220.0	224.0	151.0	337.0	129.1	134.6	92.1	200.9
1960	250.2	248.4	165.1	377.0	141.3	143.1	95.2	217.2
1961	307.0	252.1	161.9	391.4	165.6	144.5	92.6	224.5
1962	335.8	272.6	168.6	431.7	179.4	155.5	97.7	243.8
1963	390.6	294.9	175.0	474.7	214.4	164.0	97.6	263.4
1964	462.8	329.0	198.5	518.7	252.7	181.7	109.8	286.2
1965	483.5	366.7	218.2	574.0	251.2	200.3	119.0	313.8

1/ Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

Source: Outpatient Psychiatric Clinics - Annual Statistical Report, Data on Patients, 1959-1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

Table 3a

Children Served in Psychiatric Facilities, by Age, Sex, Diagnosis, and Type of Facility, United States, 1966 1/

Psychiatric Diagnosis and Sex	Outpatient Psychiatric Clinics: Terminations 2/					General Hospital Inpatient Psychiatric Facilities: Discharges 3/				
	Total under 18 years	Under 5 years	5-9 years	10-14 years	15-17 years	Total under 18 years	Under 5 years	5-9 years	10-14 years	15-17 years
Total Patients	158,062	7,456	50,217	61,349	39,040	17,815	2,495	1,784	4,277	9,259
Acute and chronic brain syndromes	6,812	966	3,195	1,929	722	3,414	1,655	520	522	717
Convulsive disorder	1,068	86	380	377	225	1,732	900	306	300	226
Psychotic disorders	5,767	263	1,316	1,773	2,415	2,938	55	137	744	2,002
Schizophrenic reactions	4,804	189	1,041	1,491	2,083	2,251	34	89	589	1,539
Psychophysiologic disorders	760	34	230	314	182	851	87	163	282	319
Psychoneurotic disorders	10,990	157	3,177	4,630	3,026	3,685	73	203	884	2,525
Anxiety reaction	4,472	90	1,654	1,897	831	1,336	28	98	354	856
Psychoneurotic depressive reaction	2,434	16	304	967	1,147	1,387	27	48	252	1,060
Personality disorders	27,124	341	5,230	11,728	9,825	2,424	102	198	592	1,532
Personality pattern disturbance	5,204	54	778	2,165	2,207	551	16	40	129	366
Personality trait disturbance	14,358	71	2,369	6,634	5,284	965	25	60	245	635
Passive aggressive personality	11,269	45	1,719	5,355	4,150	397	3	19	115	260
Transient situational personality dis.	53,459	1,715	16,863	21,609	13,272	3,152	149	296	906	1,801
Mental deficiency	10,142	1,146	4,207	3,444	1,345	1,055	351	244	261	199
Without mental disorder	4,255	676	1,590	1,333	656	72	10	5	23	34
Undiagnosed	38,753	2,158	14,409	14,589	7,597	224	13	18	63	130
Total Male	103,959	4,761	35,575	41,415	22,208	8,336	1,340	1,051	2,085	3,860
Acute and chronic brain syndromes	4,647	583	2,234	1,374	456	1,874	891	311	296	376
Convulsive disorder	654	56	241	241	116	925	494	167	160	104
Psychotic disorders	3,696	194	1,027	1,119	1,356	1,466	29	91	380	966
Schizophrenic reactions	3,098	137	816	949	1,196	1,122	16	60	296	750
Psychophysiologic disorders	437	21	145	186	85	356	41	79	138	98
Psychoneurotic disorders	6,392	108	2,177	2,858	1,249	1,306	33	105	345	823
Anxiety reaction	2,883	66	1,186	1,236	395	543	13	57	157	316
Psychoneurotic depressive reaction	1,192	8	225	570	389	453	10	26	96	321
Personality disorders	19,354	242	4,034	8,574	6,504	1,151	48	112	308	683
Personality pattern disturbance	3,489	40	568	1,504	1,377	211	8	24	57	122
Personality trait disturbance	10,387	49	1,896	4,955	3,487	478	14	34	135	295
Passive aggressive personality	8,410	31	1,399	4,082	2,898	214	1	7	67	139
Transient situational personality dis.	35,443	1,144	12,420	14,590	7,289	1,428	81	197	430	720
Mental deficiency	6,263	725	2,596	2,123	819	615	202	141	154	118
Without mental disorder	2,568	393	997	813	365	36	9	3	10	14
Undiagnosed	25,159	1,351	9,945	9,778	4,085	104	6	12	24	62
Total Female	54,103	2,695	14,642	19,934	16,832	9,479	1,155	733	2,192	5,399
Acute and chronic brain syndromes	2,165	383	961	555	266	1,540	764	209	226	341
Convulsive disorder	414	30	139	136	109	807	406	139	140	122
Psychotic disorders	2,071	69	289	654	1,059	1,472	26	46	364	1,036
Schizophrenic reactions	1,706	52	225	542	887	1,129	18	29	293	789
Psychophysiologic disorders	323	13	85	128	97	495	46	84	144	221
Psychoneurotic disorders	4,598	49	1,000	1,772	1,777	2,379	40	98	539	1,702
Anxiety reaction	1,589	24	468	661	436	793	15	41	197	540
Psychoneurotic depressive reaction	1,242	8	79	397	758	934	17	22	156	739
Personality disorders	7,770	99	1,196	3,154	3,321	1,273	54	86	284	849
Personality pattern disturbance	1,715	14	210	661	830	340	8	16	72	244
Personality trait disturbance	3,971	22	473	1,679	1,797	487	11	26	110	340
Passive aggressive personality	2,859	14	320	1,273	1,252	183	2	12	48	121
Transient situational personality dis.	18,016	571	4,443	7,019	5,983	1,724	68	99	476	1,081
Mental deficiency	3,879	421	1,611	1,321	526	440	149	103	107	81
Without mental disorder	1,687	283	593	520	291	36	1	2	13	20
Undiagnosed	13,594	807	4,464	4,811	3,512	120	7	6	39	68

1/ Provisional data.

2/ Includes data from 1439 of 1899 known clinics (excludes clinics of the Veterans Administration).

3/ Includes data from 650 of 888 known hospitals.

Table 3 b

Children Served in Psychiatric Facilities, by Age, Sex. Diagnosis, and Type of Facility, United States, 1966 1/

Psychiatric Diagnosis and Sex	State and County Mental Hospitals									
	First Admissions 2/					Resident Patients 3/				
	Total under 18 years	Under 5 years	5-9 years	10-14 years	15-17 years	Total under 18 years	Under 5 years	5-9 years	10-14 years	15-17 years
Total Patients	10,182	114	1,038	3,216	5,814	10,309	108	1,325	3,937	4,939
Acute and chronic brain syndromes	796	52	158	268	318	1,599	74	318	598	609
Convulsive disorder	311	6	35	108	162	544	16	56	173	299
Psychotic disorders	2,283	17	296	653	1,317	3,349	17	419	1,195	1,718
Schizophrenic reactions	2,064	11	268	609	1,176	3,033	9	356	1,080	1,588
Psychophysiologic disorders	21	-	1	9	11	6	-	-	2	4
Psychoneurotic disorders	589	2	30	188	369	326	-	28	144	154
Anxiety reaction	144	-	10	58	76	82	-	8	48	26
Psychoneurotic depressive reaction	232	1	6	57	168	113	-	8	35	70
Personality disorders	1,727	6	66	415	1,240	938	-	53	316	569
Personality pattern disturbance	305	-	11	77	217	203	-	9	56	138
Personality trait disturbance	764	4	43	230	487	518	-	34	226	258
Passive aggressive personality	457	2	29	158	268	325	-	20	131	174
Transient situational personality dis.	3,128	10	341	1,136	1,641	2,240	2	284	1,020	934
Mental deficiency	855	17	92	304	442	1,227	11	148	421	647
Without mental disorder	179	4	5	38	132	80	-	5	22	53
Undiagnosed	604	6	49	205	344	544	4	70	219	251
Total Male	6,362	72	825	2,003	3,462	6,866	60	1,020	2,762	3,024
Acute and chronic brain syndromes	545	36	128	174	207	1,080	39	211	422	408
Convulsive disorder	191	3	31	61	96	346	7	38	110	191
Psychotic disorders	1,348	12	232	370	734	2,172	11	333	819	1,009
Schizophrenic reactions	1,222	7	210	346	659	1,962	6	286	741	929
Psychophysiologic disorders	6	-	-	3	3	1	-	-	1	-
Psychoneurotic disorders	248	-	24	93	131	180	-	23	93	64
Anxiety reaction	73	-	6	31	36	55	-	6	32	17
Psychoneurotic depressive reaction	79	-	6	25	48	50	-	7	18	25
Personality disorders	1,185	5	55	273	852	682	-	44	231	407
Personality pattern disturbance	220	-	9	58	153	160	-	7	47	106
Personality trait disturbance	488	3	35	144	306	357	-	28	160	169
Passive aggressive personality	314	2	24	106	182	227	-	17	91	119
Transient situational personality dis.	1,924	5	280	726	913	1,536	-	239	758	539
Mental deficiency	573	8	66	200	299	804	7	112	274	411
Without mental disorder	141	2	4	30	105	52	-	4	12	36
Undiagnosed	392	4	36	134	218	359	3	54	152	150
Total Female	3,820	42	213	1,213	2,352	3,443	48	305	1,175	1,915
Acute and chronic brain syndromes	251	16	30	94	111	519	35	107	176	201
Convulsive disorder	120	3	4	47	66	198	9	18	63	108
Psychotic disorders	935	5	64	283	583	1,177	6	86	376	709
Schizophrenic reactions	842	4	58	263	517	1,071	3	70	339	659
Psychophysiologic disorders	15	-	1	6	8	5	-	-	1	4
Psychoneurotic disorders	341	2	6	95	238	146	-	5	51	90
Anxiety reaction	71	-	4	27	40	27	-	2	16	9
Psychoneurotic depressive reaction	153	1	-	32	120	63	-	1	17	45
Personality disorders	542	1	11	142	388	256	-	9	85	162
Personality pattern disturbance	85	-	2	19	64	43	-	2	9	32
Personality trait disturbance	276	1	8	86	181	161	-	6	66	89
Passive aggressive personality	143	-	5	52	86	98	-	3	40	55
Transient situational personality dis.	1,204	5	61	410	728	704	2	45	262	395
Mental deficiency	282	9	26	104	143	423	4	36	147	236
Without mental disorder	38	2	1	8	27	28	-	1	10	17
Undiagnosed	212	2	13	71	126	185	1	16	67	101

1/ Provisional data.

2/ Includes data from 219 of 298 known hospitals.

3/ Includes data from 211 of 298 known hospitals.

Table 3c

Children Served in Psychiatric Facilities, by Age, Sex, Diagnosis, and Type of Facility, United States, 1966 1/

Psychiatric Diagnosis and Sex	Private Mental Hospitals									
	First Admissions 2/					Resident Patients 3/				
	Total under 18 years	Under 5 years	5-9 years	10-14 years	15-17 years	Total under 18 years	Under 5 years	5-9 years	10-14 years	15-17 year
Total Patients	3,033	13	105	836	2,079	1,440	15	86	510	8
Acute and chronic brain syndromes	160	3	21	57	79	252	-	30	119	1
Convulsive disorder	41	1	4	12	24	33	-	6	15	
Psychotic disorders	730	1	15	163	551	319	-	14	92	2
Schizophrenic reactions	572	1	10	125	436	284	-	12	84	1
Psychophysiologic disorders	14	-	-	5	9	5	-	-	2	
Psychoneurotic disorders	504	-	12	125	367	143	11	4	43	1
Anxiety reaction	108	-	2	31	75	36	-	-	17	1
Psychoneurotic depressive reaction	266	-	3	49	214	55	2	2	13	
Personality disorders	641	3	25	171	442	375	1	21	152	2
Personality pattern disturbance	177	-	2	54	121	91	-	6	34	
Personality trait disturbance	266	1	20	65	180	222	1	14	98	10
Passive aggressive personality	142	-	17	38	87	165	1	11	76	7
Transient situational personality dis.	796	3	13	249	531	217	-	9	62	14
Mental deficiency	52	2	10	22	18	57	-	4	23	3
Without mental disorder	17	1	4	5	7	2	-	1	-	
Undiagnosed	119	-	5	39	75	70	3	3	17	4
Total Male	1,582	8	78	467	1,029	877	9	61	350	45
Acute and chronic brain syndromes	109	2	17	38	52	177	-	24	80	7
Convulsive disorder	22	-	3	9	10	17	-	3	9	
Psychotic disorders	357	-	9	78	270	184	-	6	60	11
Schizophrenic reactions	299	-	5	69	225	167	-	5	55	10
Psychophysiologic disorders	1	-	-	1	-	-	-	-	-	
Psychoneurotic disorders	226	-	7	67	152	90	9	3	31	4
Anxiety reaction	61	-	1	20	40	27	-	-	16	1
Psychoneurotic depressive reaction	107	-	2	24	81	33	-	2	9	2
Personality disorders	382	2	22	108	250	256	-	18	120	11
Personality pattern disturbance	99	-	-	36	63	67	-	4	27	3
Personality trait disturbance	161	-	19	44	98	151	-	13	75	6
Passive aggressive personality	107	-	16	30	61	126	-	10	64	5
Transient situational personality dis.	401	1	11	135	254	109	-	5	38	6
Mental deficiency	44	2	6	19	17	37	-	2	14	2
Without mental disorder	7	1	3	1	2	1	-	1	-	
Undiagnosed	55	-	3	20	32	23	-	2	7	1
Total Female	1,451	5	27	369	1,050	563	6	25	160	3
Acute and chronic brain syndromes	51	1	4	19	27	75	-	6	30	
Convulsive disorder	19	1	1	3	14	16	-	3	6	
Psychotic disorders	373	1	6	85	281	135	-	8	32	
Schizophrenic reactions	273	1	5	56	211	117	-	7	29	
Psychophysiologic disorders	13	-	-	4	9	5	-	-	2	
Psychoneurotic disorders	278	-	5	58	215	53	2	1	12	
Anxiety reaction	47	-	1	11	35	9	-	-	1	
Psychoneurotic depressive reaction	159	-	1	25	133	22	2	-	4	
Personality disorders	259	1	3	63	192	110	1	3	32	
Personality pattern disturbance	78	-	2	18	58	24	-	2	7	
Personality trait disturbance	105	1	1	21	82	71	1	1	23	
Passive aggressive personality	35	-	1	8	26	30	1	1	12	
Transient situational personality dis.	395	2	2	114	277	108	-	4	24	
Mental deficiency	8	-	4	3	1	20	-	2	9	
Without mental disorder	10	-	1	4	5	1	-	-	-	
Undiagnosed	64	-	2	10	43	47	3	1	10	

1/ Provisional data.

2/ Includes data from 152 of 174 known hospitals.

3/ Includes data from 148 of 174 known hospitals reporting as of December 31.

Table 4

Person Interviewed, by Age of Patient, Total and Treated Adolescent Patients Terminated from 754 Outpatient Psychiatric Clinics, United States, 1962

Person seen (interviewed)	Total	Age at admission				
		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years
Total number of patients	51,537	11,759	11,546	12,990	8,809	6,433
Percent of patients by interviews with:						
Patients only	22.1	9.9	12.7	17.9	28.7	61.2
Patient, parent(s) only	50.6	60.7	57.4	52.3	45.6	23.8
Patient, parent(s), others	11.9	13.4	13.8	13.1	11.0	4.7
Patient, others only	5.7	3.5	4.7	6.4	7.2	8.1
Parent(s), others only	.7	.8	.7	.7	.6	.2
Parent(s) only	8.7	11.6	10.5	9.3	6.6	1.8
Others only	.2	.1	.2	.3	.3	.2
Number of treated patients	16,756	3,734	3,573	3,743	2,971	2,735
Percent of patients by interviews with:						
Patients only	21.1	4.8	7.9	14.1	28.6	62.0
Patient, parent(s) only	59.3	73.5	70.3	65.8	52.9	23.6
Patient, parent(s), others	14.6	18.4	18.2	15.6	12.6	5.6
Patient, others only	4.0	1.9	2.4	3.6	5.2	8.5
Parent(s), others only	.2	.2	.3	.1	.1	.1
Parent(s) only	.7	1.1	.8	.6	.4	.3
Others only	.1	.1	.1	.2	.2	-

Source: Adolescent Patients Served in Outpatient Psychiatric Clinics (Table 3) by B.M. Rosen, A.K. Bahn, R. Shellow and E.M. Bower. American Journal of Public Health 55: 1563-1577, October 1965.

Table 5

Number and Location of Psychiatric Facilities in the United States, 1966[1]

STATE	Number of Known Psychiatric Facilities				
	Outpatient Psychiatric Clinics [2]	State and County Mental Hospitals	Private Mental Hospitals	General Hospital Inpatient Psychiatric Facilities	Psychiatric Day/Night Units[3]
United States	2079	298	174	888	173
Alabama	25	2	1	11	0
Alaska	3	2	-	6	1
Arizona	12	1	2	5	2
Arkansas	7	2	-	5	0
California	189	12	25	56	28
Colorado	25	2	3	11	4
Connecticut	50	4	7	14	8
Delaware	11	2	-	3	1
District of Columbia	21	1	-	6	4
Florida	33	4	5	31	1
Georgia	28	2	5	10	0
Hawaii	14	1	-	6	1
Idaho	3	2	-	4	0
Illinois	117	14	10	56	9
Indiana	27	9	2	32	2
Iowa	26	6	1	16	1
Kansas	34	3	2	17	3
Kentucky	24	4	3	10	3
Louisiana	29	3	1	12	3
Maine	17	3	1	5	0
Maryland	78	7	7	9	7
Massachusetts	125	13	11	31	14
Michigan	82	10	10	33	6
Minnesota	29	8	-	28	4
Mississippi	6	2	-	4	1
Missouri	39	7	3	19	3
Montana	5	1	-	6	0
Nebraska	10	4	1	11	2
Nevada	5	1	-	5	0
New Hampshire	30	1	-	4	0
New Jersey	78	12	4	28	1
New Mexico	4	1	1	3	1
New York	392	24	19	58	13
North Carolina	43	4	3	12	1
North Dakota	2	1	-	7	0
Ohio	77	21	4	43	12
Oklahoma	11	4	1	16	3
Oregon	29	3	1	12	2
Pennsylvania	137	20	16	58	14
Rhode Island	16	1	2	7	3
South Carolina	13	2	1	7	0
South Dakota	6	1	-	9	0
Tennessee	17	6	2	8	4
Texas	35	8	6	68	0
Utah	17	1	-	8	1
Vermont	1	1	1	5	0
Virginia	30	4	5	15	4
Washington	12	3	2	14	3
West Virginia	11	5	1	4	0
Wisconsin	38	42	5	33	2
Wyoming	6	1	-	7	1

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[1] Provisional data.

[2] Excludes clinics of the Veterans Administration.

[3] As of 1965.

TABLE 6

Rank Order Of States According To Number Of Scheduled Professional Man-Hours Per Week Per 100,000 Population, Outpatient Psychiatric Clinics, 1965

Rank	State	Total Clinics	Number of Clinics Reporting	Number of Man-Hours Per 100,000 Population
	Total United States			221[1]
1	District of Columbia	22	16	758
2	Massachusetts	122	121	626
3.	New York	380	373	451
4	Colorado	25	25	346
5	Kansas	34	32	323
6	Connecticut	49	49	314
7	Delaware	14	12	299
8	New Hampshire	27	27	297
9	Illinois	108	108	294
10	Rhode Island	16	16	288
11	Pennsylvania	141	141	274
12	Maryland	71	70	262
13	Hawaii	11	11	251
14	California	142	129	245
15	Michigan	60	57	225
16	Minnesota	27	26	224
17	Louisiana	29	28	218
18	New Jersey	80	78	204
19	Iowa	29	25	182
20	Ohio	78	72	168
21	Missouri	41	37	164
22	Wisconsin	34	34	161
23	Florida	37	36	153
24	Oregon	22	21	145
25	Virginia	30	29	138
26	Indiana	27	27	137
27	Wyoming	6	5	132
28	Vermont	7	7	126
29	Utah	18	13	125
30	Kentucky	30	27	124
31	Arizona	8	7	118
32	Oklahoma	24	24	116
33	New Mexico	5	5	115
34	Alaska	3	3	113
35	Nebraska	11	9	106
36	North Carolina	38	28	104
37	Washington	13	12	98
38	Tennessee	15	15	91
39	Georgia	23	23	89
40	South Dakota	6	6	85
41	Texas	41	40	78
42	Montana	5	5	77
43	Alabama	25	25	76
44	Maine	10	10	72
45	Arkansas	8	8	70
46	South Carolina	11	11	60
47	Nevada	5	5	58
48	North Dakota	3	2	45
49	West Virginia	13	9	41
50	Idaho	3	3	25
51	Mississippi	7	7	23

[1] Data based on reports from 1919 clinics including 65 clinics of the Veterans Administration, Puerto Rico and Virgin Islands.

Source: Outpatient Psychiatric Clinics, Data on Staff and Man-Hours, 1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

Table 7

Distribution of Rural Clinics for Children and Rural Clinic Population by Geographic Region and State, 1965 [1]

Geographic Region and State	Number of Rural Clinics Serving Children	Rural Clinic Population under 18 Years of Age [2]	
		Number	Percent of Total Clinic Population under 18 Years
Total United States[3]	234	25,004	8.4
Northeast	89	8,705	6.0
Connecticut	2	102	1.9
Maine	1	90	12.6
Massachusetts	3	279	2.4
New Hampshire	3	522	30.0
New Jersey	3	654	4.3
New York	57	6,380	6.9
Pennsylvania	14	678	4.1
2 other States	6	—	—
North Central	60	7,231	12.3
Iowa	9	928	24.8
Kansas	5	287	9.1
Michigan	5	1,324	9.0
Minnesota	10	2,337	41.2
Missouri	6	254	6.2
Ohio	6	899	7.4
Wisconsin	8	1,202	20.6
5 other States	11	—	—
South	63	6,905	11.3
Alabama	3	178	5.5
Florida	2	321	3.2
Georgia	1	5	0.2
Kentucky	7	430	14.1
Louisiana	5	703	10.9
Maryland	11	970	17.7
Mississippi	2	287	30.9
North Carolina	18	2,417	39.6
South Carolina	4	987	48.0
Tennessee	2	307	8.5
Virginia	2	117	1.8
West Virginia	4	183	16.1
5 other States	2	—	—
West	22	2,163	6.5
California	7	1,032	5.5
Colorado	3	280	6.4
Hawaii	1	110	10.6
Nevada	1	174	34.3
Oregon	4	527	13.2
Wyoming	1	40	2.1
7 other States	5	—	—

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[1] Includes clinics located in counties which were 50% or more rural in the 1960 Census of Population.

[2] Excludes rural children who are seen in urban clinics.

[3] Estimated figures for clinics in some states.

Source: Rural Outpatient Mental Health Services for Children, 1965 (Table 2) by B.M. Rosen, NIMH, 1968.

Table 8

Percent of Psychiatric Day-Night Services Providing Specified Types of Treatment by Type of Unit, United States, 1965 1/

Treatments provided	Total day-night units	Other than Veterans Administration Units									Veterans Administration units
					Affiliation			Age Group Served			
		Total	Day	Day and night, and night only	Inpa-tient and out-patient	Hospital (mental, general, other)	All other 3/	Children only 4/	Adults only 5/	Children and adults only 6/	
Total services reporting	174 2/	152	121	31	94	32	26	28	80	44	22
Percent providing specified services:											
Diagnosis and/or observation only	58	60	61	58	62	56	62	68	56	64	36
Individual therapy	91	90	88	97	94	84	85	89	88	96	100
Group therapy	94	93	91	100	97	84	88	82	98	91	100
Family therapy	72	72	72	74	78	56	73	79	74	66	68
Chemotherapy	91	90	88	100	98	94	58	64	99	91	100
Somatic therapy	44	47	42	68	52	59	15	11	50	66	18
Occupational therapy	93	92	90	100	95	97	77	71	98	96	100
Recreational therapy	93	92	91	97	97	100	65	79	95	96	100
Vocational counseling	54	49	46	61	52	53	35	18	54	61	86
Educational therapy	62	59	58	64	60	53	65	100	42	64	82
Other services	10	9	7	16	8	12	4	4	14	2	18

1/ Includes two units in Puerto Rico

2/ Excludes one unit which did not report this item.

3/ Includes independent units, those affiliated with outpatient clinics and others.

4/ Includes units serving children and adolescents.

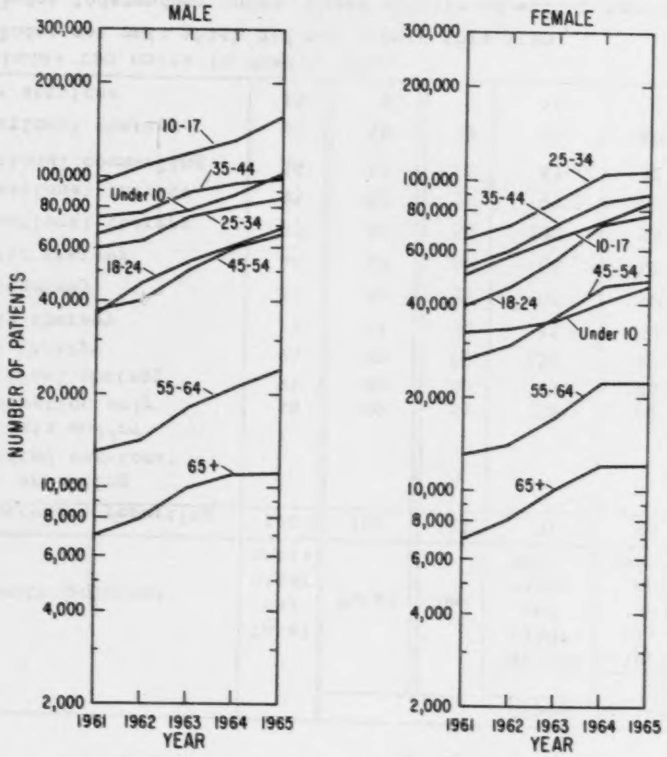
5/ Includes units serving adolescents and adults; adolescents, adults and aged; adults and aged; one unit which serves 60 and over only.

6/ Units have no restrictions at all. Includes 4 who do not serve children under 3, 6 or 10 years of age.

Source: A Survey of Psychiatric Day-Night Services in the United States, 1965 (Table 2) by S.G. Willner and B.M. Rosen, NIMH, April 1967.

FIGURE 1a

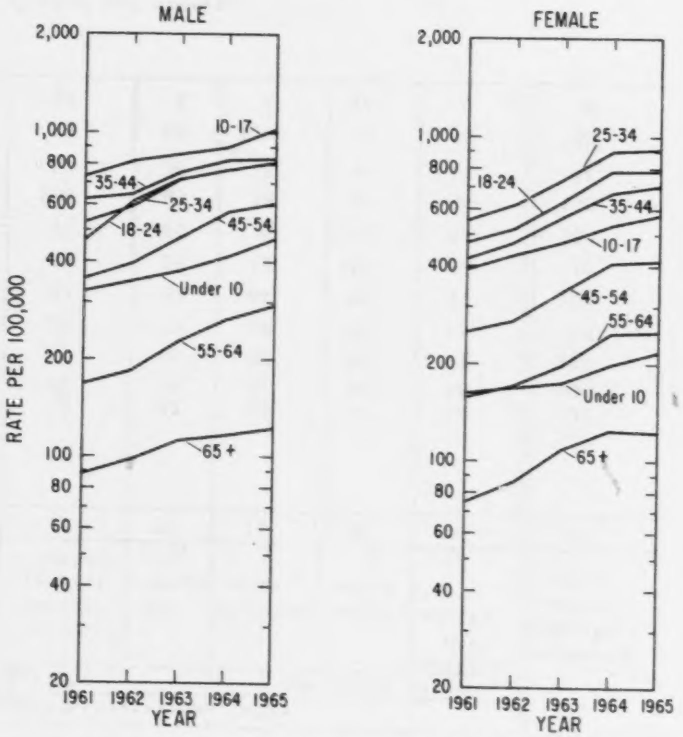
ESTIMATED NUMBER OF PATIENTS UNDER CARE DURING THE YEAR, OUTPATIENT PSYCHIATRIC CLINICS, BY AGE AND SEX, UNITED STATES, 1961-1965



Source: Outpatient Psychiatric Clinics, Annual Statistical Report, Data on Patients, 1961-1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

FIGURE 1b

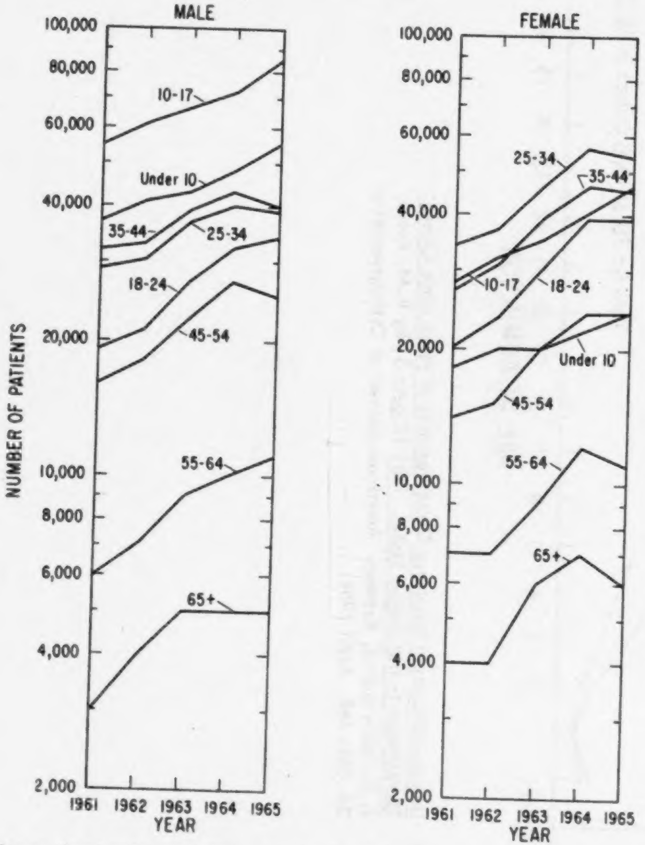
PATIENTS UNDER CARE DURING THE YEAR, PER 100,000 POPULATION, OUTPATIENT PSYCHIATRIC CLINICS, BY AGE AND SEX, UNITED STATES, 1961-1965



Source: Outpatient Psychiatric Clinics, Annual Statistical Report, Data on Patients, 1961-1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

FIGURE 2a

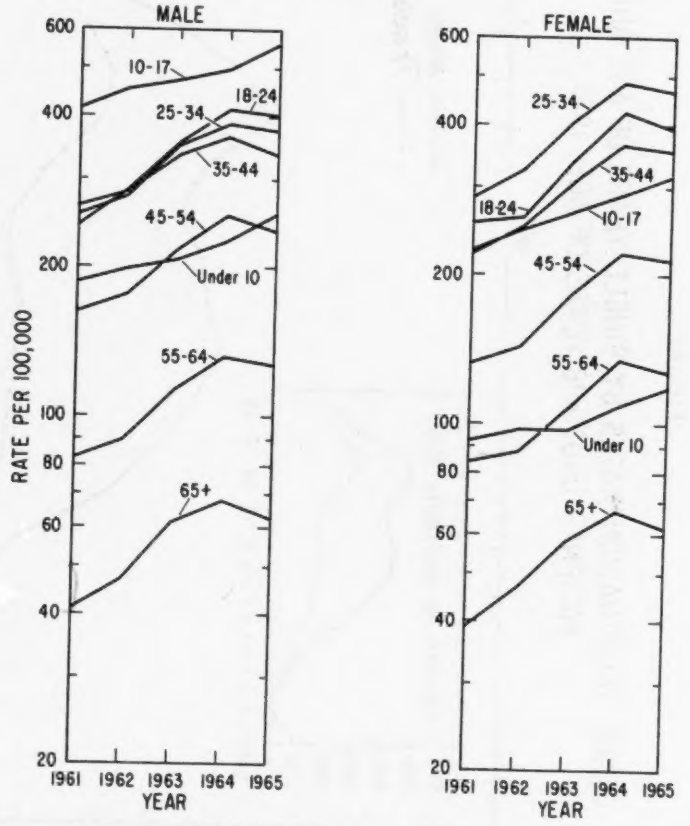
ESTIMATED NUMBER OF TERMINATIONS FROM OUTPATIENT PSYCHIATRIC CLINICS, BY AGE AND SEX, UNITED STATES, 1961 - 1965



Source: Outpatient Psychiatric Clinics, Annual Statistical Report, Data on Patients, 1961 - 1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

FIGURE 2b

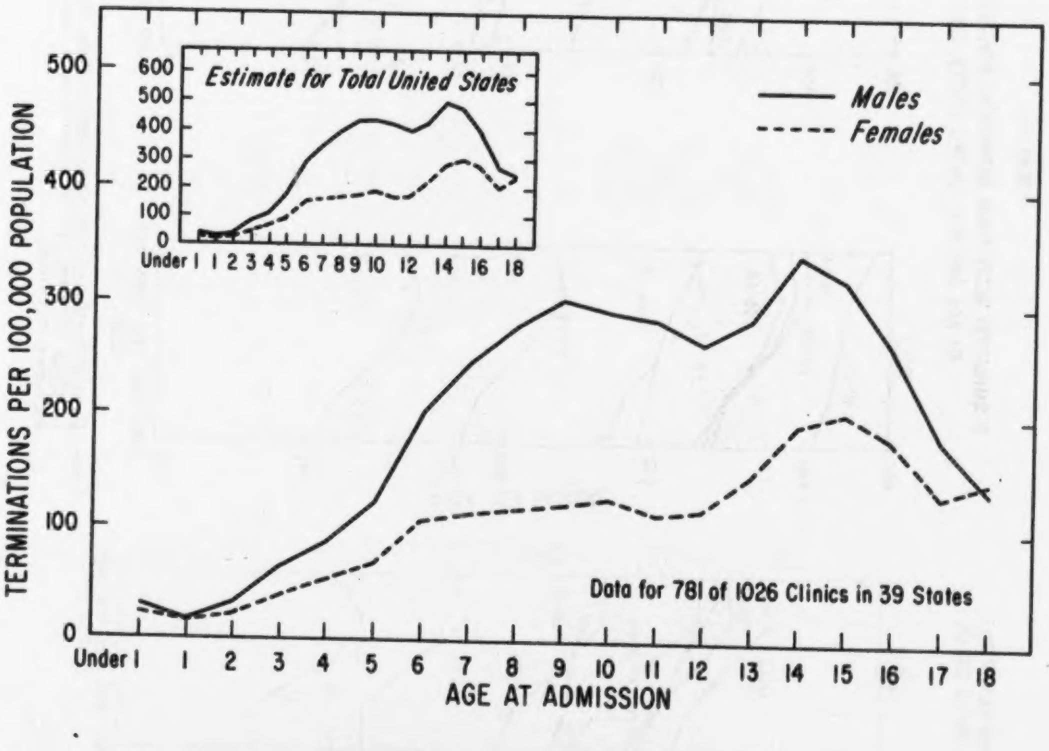
TERMINATION RATES FROM OUTPATIENT PSYCHIATRIC CLINICS, BY AGE AND SEX, UNITED STATES, 1961-1965



Source: Outpatient Psychiatric Clinics, Annual Statistical Report, Data on Patients, 1961 - 1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

FIGURE 3

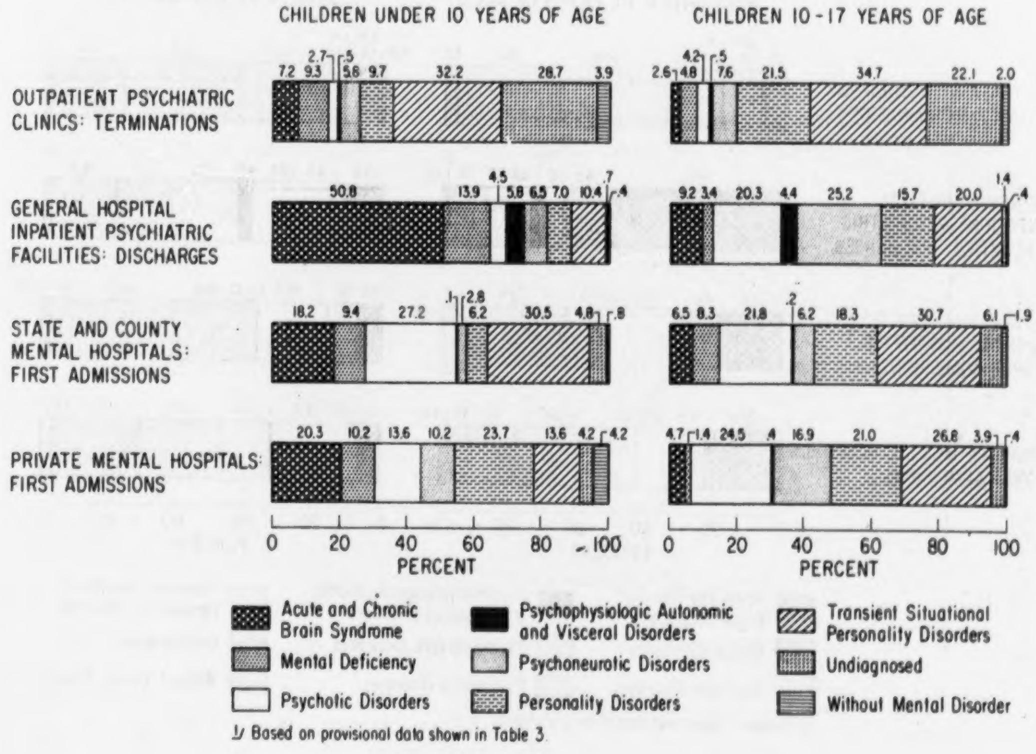
CLINIC TERMINATION RATES BY SINGLE YEARS OF AGE AND SEX, PATIENTS UNDER 18 YEARS OF AGE, 1961



Source: Demographic and Diagnostic Characteristics of Psychiatric Clinic Outpatients in the United States, 1961 (Figure 3) by B.M. Rosen, A.K. Bahn and M. Kramer. American Journal of Orthopsychiatry 34: 455-468, April 1964.

FIGURE 4a

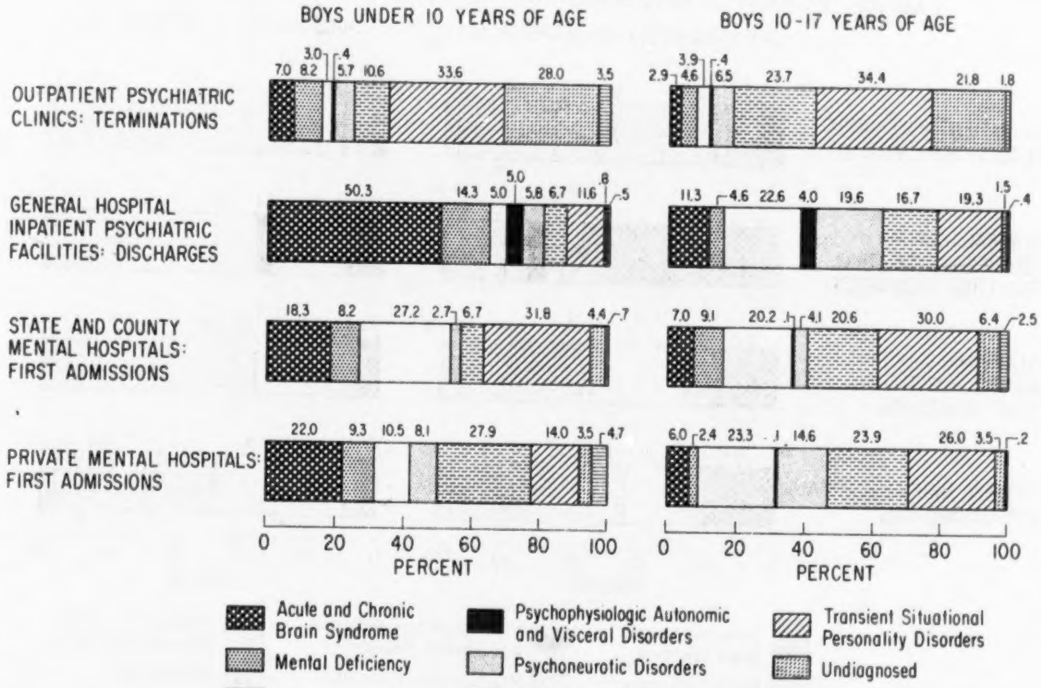
PERCENT DISTRIBUTION OF CHILDREN UNDER 10 AND 10-17 YEARS OF AGE, BY DIAGNOSIS, AND FOR TYPE OF PSYCHIATRIC FACILITY IN WHICH SERVED, UNITED STATES, 1966 1/



1/ Based on provisional data shown in Table 3.

FIGURE 4b

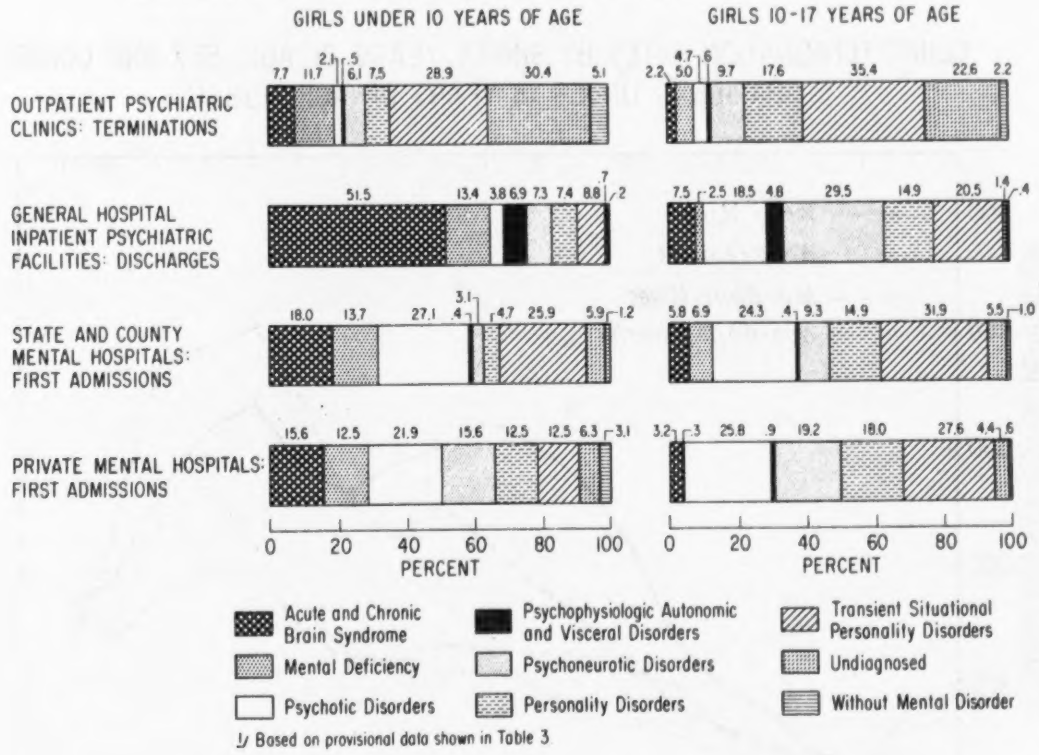
PERCENT DISTRIBUTION OF BOYS UNDER 10 AND 10-17 YEARS OF AGE, BY DIAGNOSIS AND FOR TYPE OF PSYCHIATRIC FACILITY IN WHICH SERVED, UNITED STATES, 1966[1/]



1/ Based on provisional data shown in Table 3

FIGURE 4c

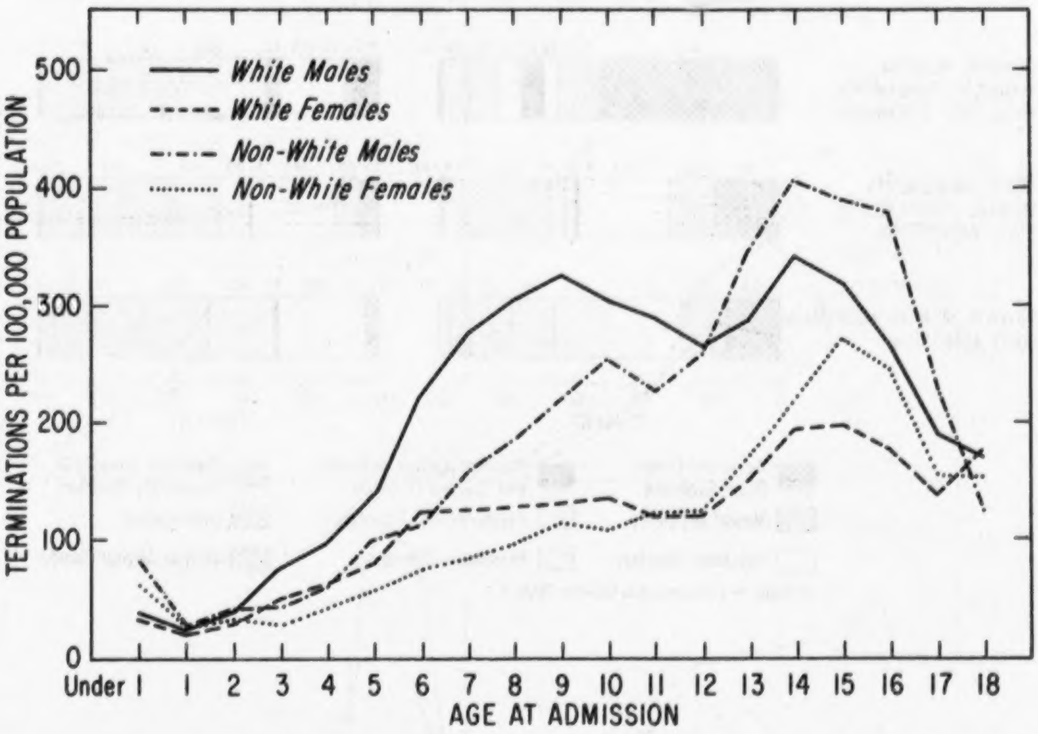
PERCENT DISTRIBUTION OF GIRLS UNDER 10 AND 10-17 YEARS OF AGE, BY DIAGNOSIS, AND FOR TYPE OF PSYCHIATRIC FACILITY IN WHICH SERVED, UNITED STATES, 1966[1/]



[1/] Based on provisional data shown in Table 3

FIGURE 5

CLINIC TERMINATION RATES BY SINGLE YEARS OF AGE, SEX AND COLOR, PATIENTS UNDER 18 YEARS OF AGE, 1961[1]

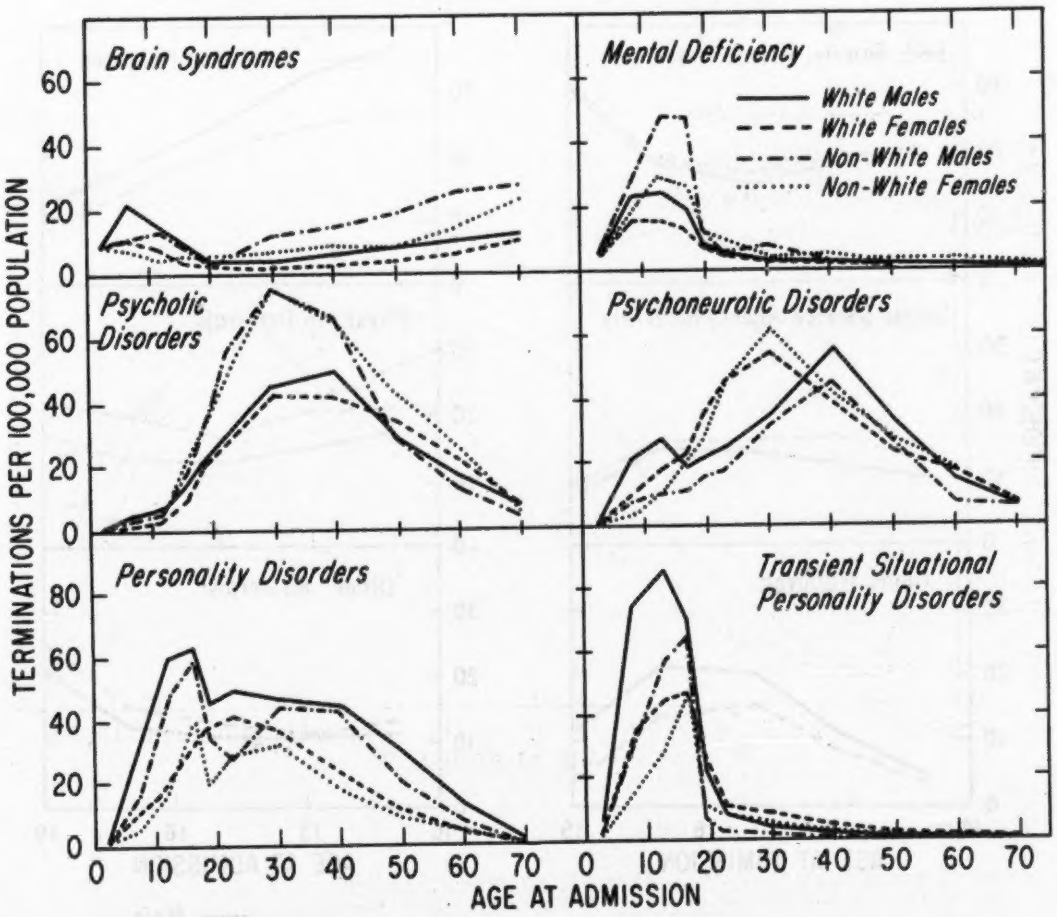


[1] Data for 525 of 616 clinics in 24 states.

Source: Demographic and Diagnostic Characteristics of Psychiatric Clinic Outpatients in the United States, 1961 (Figure 5) by B.M. Rosen, A.K. Bahn and M. Kramer. American Journal of Orthopsychiatry 34: 455-468, April 1964.

FIGURE 6

CLINIC TERMINATION RATES BY COLOR, AGE AND SEX, FOR EACH MAJOR PSYCHIATRIC DISORDER, 1961 [1]

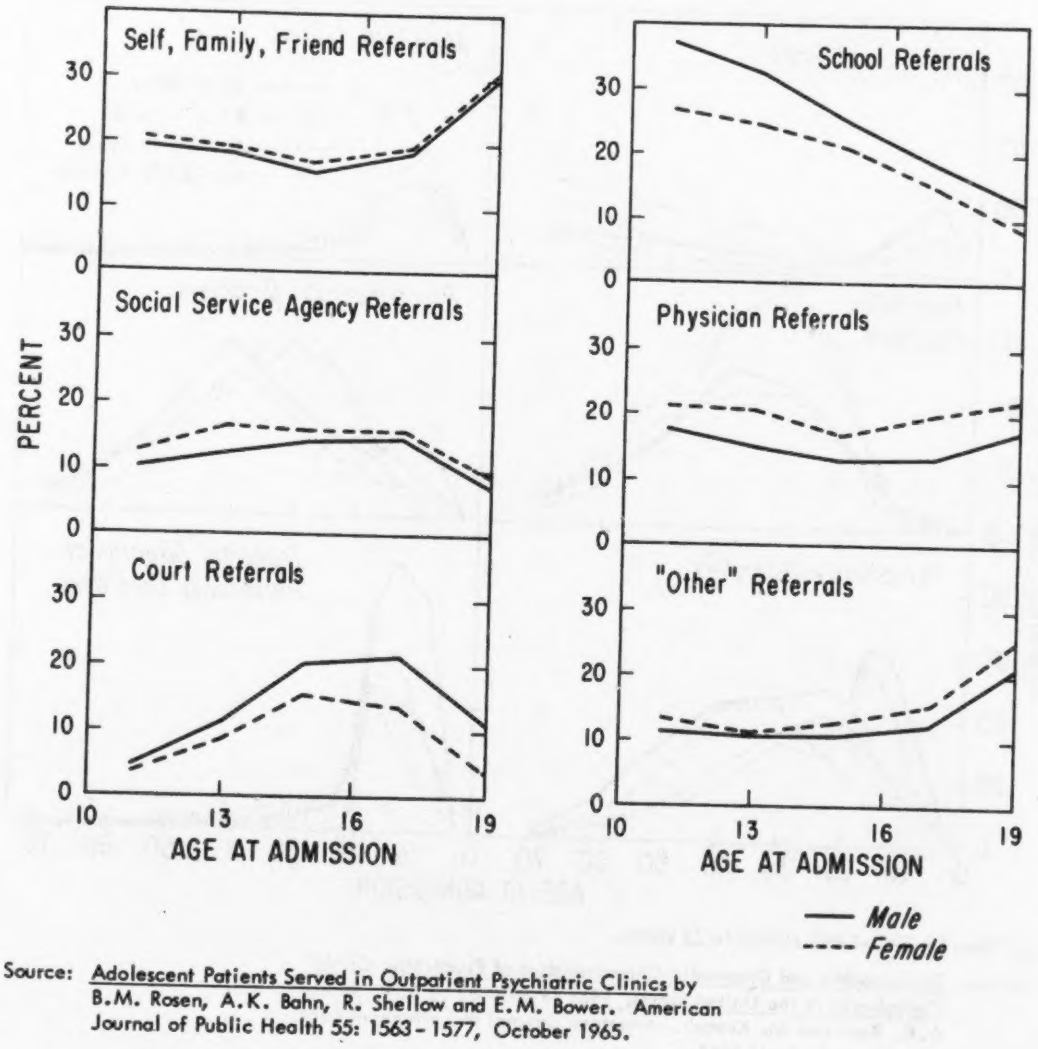


[1] Data for 579 of 682 clinics in 25 states.

Source: Demographic and Diagnostic Characteristics of Psychiatric Clinic Outpatients in the United States, 1961 (Figure 8) by B.M. Rosen, A.K. Bahn and M. Kramer. American Journal of Orthopsychiatry 34: 455-468, April 1964.

FIGURE 7

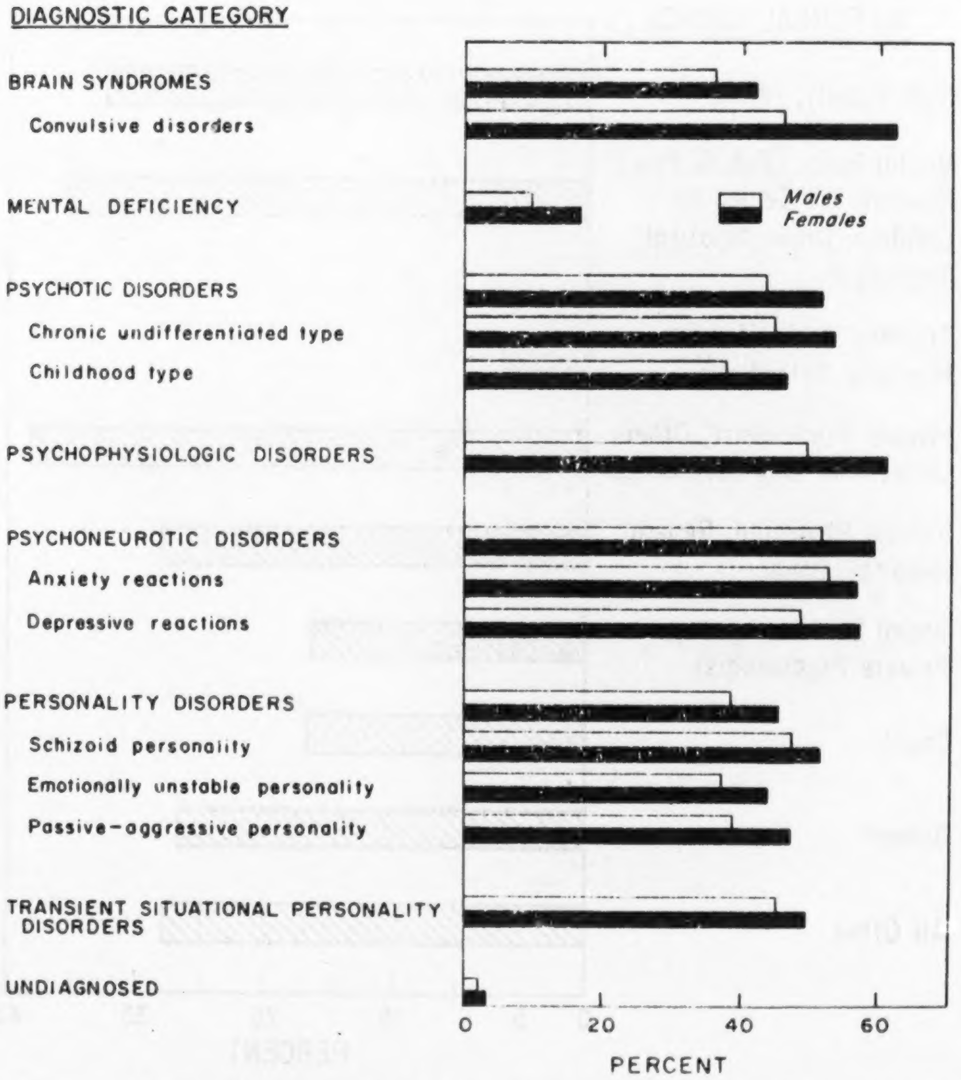
PERCENT DISTRIBUTION BY REFERRAL SOURCE, AGE AND SEX, ADOLESCENT PATIENTS TERMINATED FROM 780 OUTPATIENT PSYCHIATRIC CLINICS, UNITED STATES, 1962



Source: Adolescent Patients Served in Outpatient Psychiatric Clinics by B.M. Rosen, A.K. Bahn, R. Shellow and E.M. Bower. American Journal of Public Health 55: 1563-1577, October 1965.

FIGURE 8

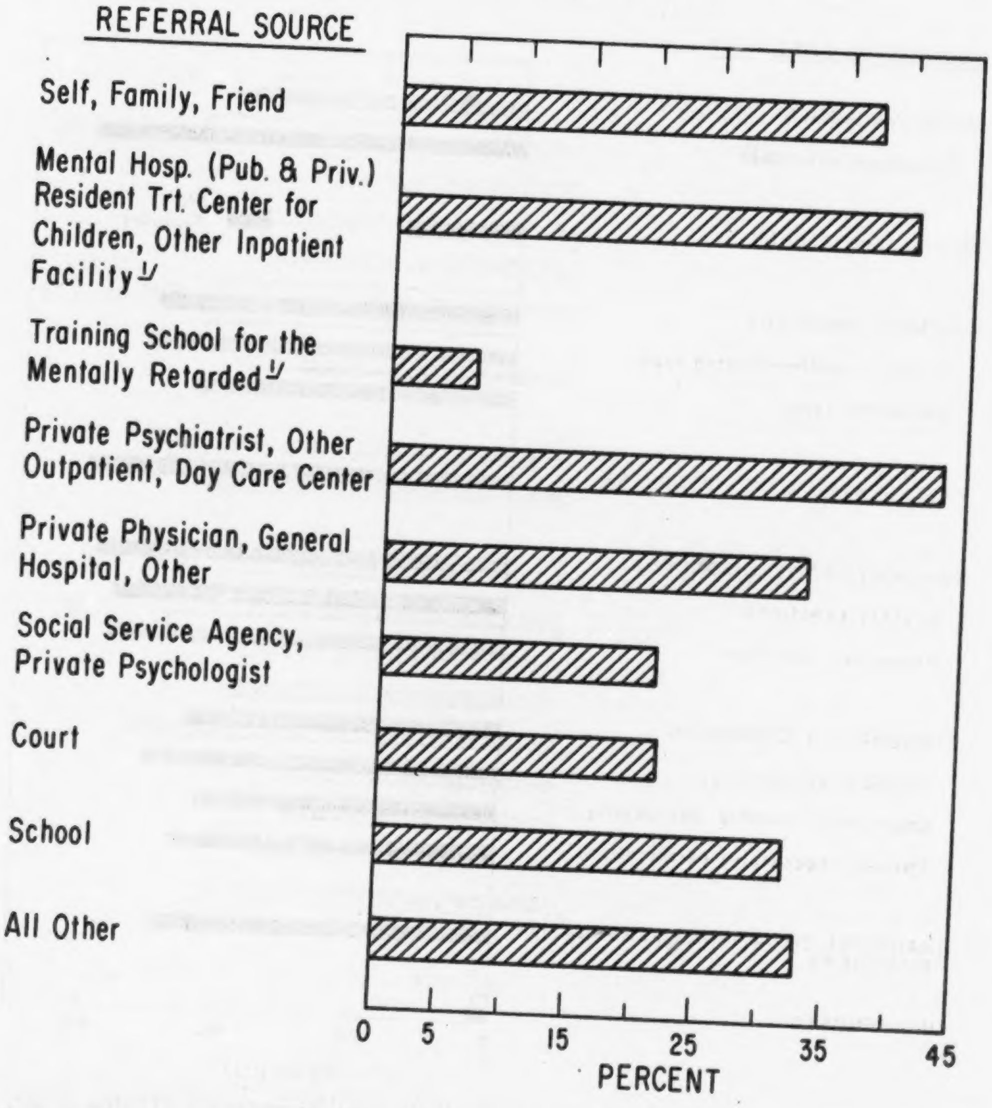
PERCENT OF PATIENTS WHO WERE TREATED, BY DIAGNOSTIC CATEGORY AND SEX, ADOLESCENT PATIENTS TERMINATED FROM 788 OUTPATIENT PSYCHIATRIC CLINICS, U.S., 1962



Source: Adolescent Patients Served in Outpatient Psychiatric Clinics (Figure 4b) by B. M. Rosen, A. K. Bahn, R. Shellow, and E. M. Bower. American Journal of Public Health 55: 1563-1577, October 1965.

FIGURE 9

PERCENT TREATED BY REFERRAL SOURCE FOR PATIENTS UNDER 18 YEARS OF AGE TERMINATED FROM 801 OUTPATIENT PSYCHIATRIC CLINICS, UNITED STATES, 1963

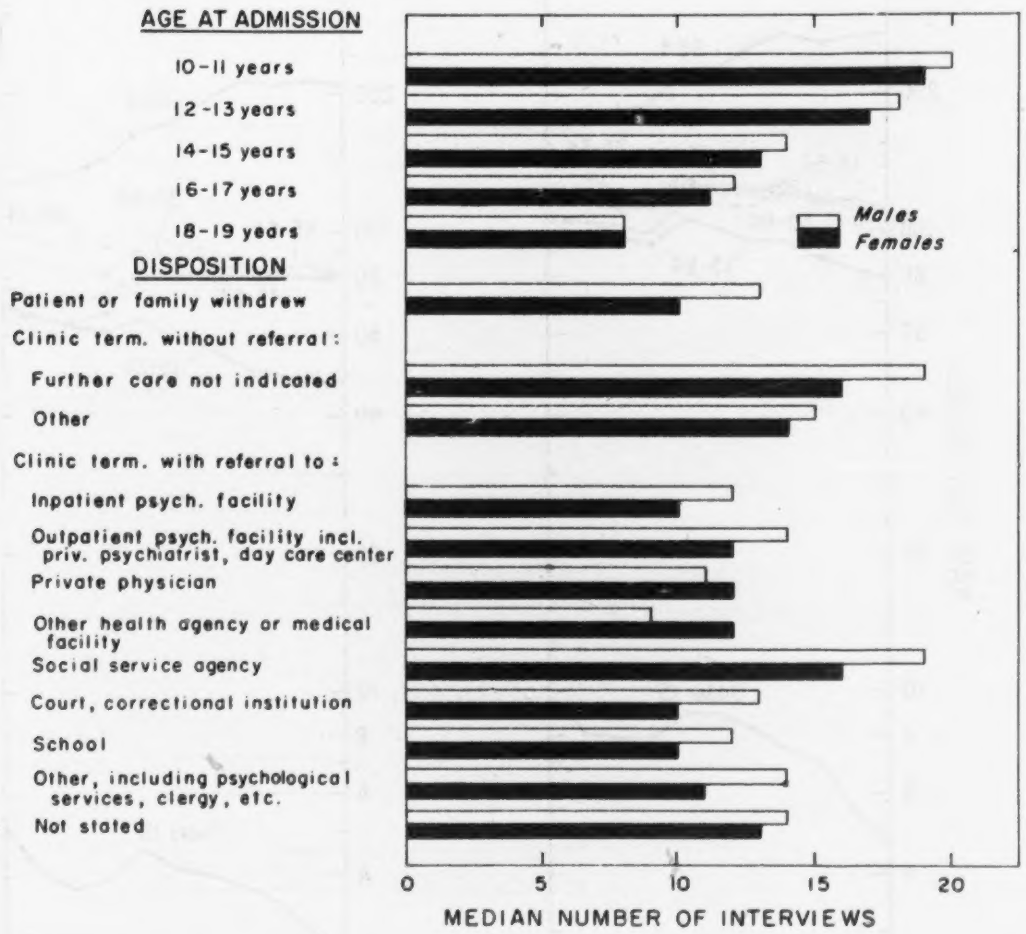


1/ Groups omitted if less than 25 patients were reported.

Source: A Nationwide Survey of Outpatient and Other Psychiatric Services to Two Diagnostic Groups, Mentally Deficient Children and Psychotic Adults, 1963 (Figure 2) by B.M. Rosen, A.K. Bahn, B.S. Brown and P.H. Person. NIMH, 1966.

FIGURE 10

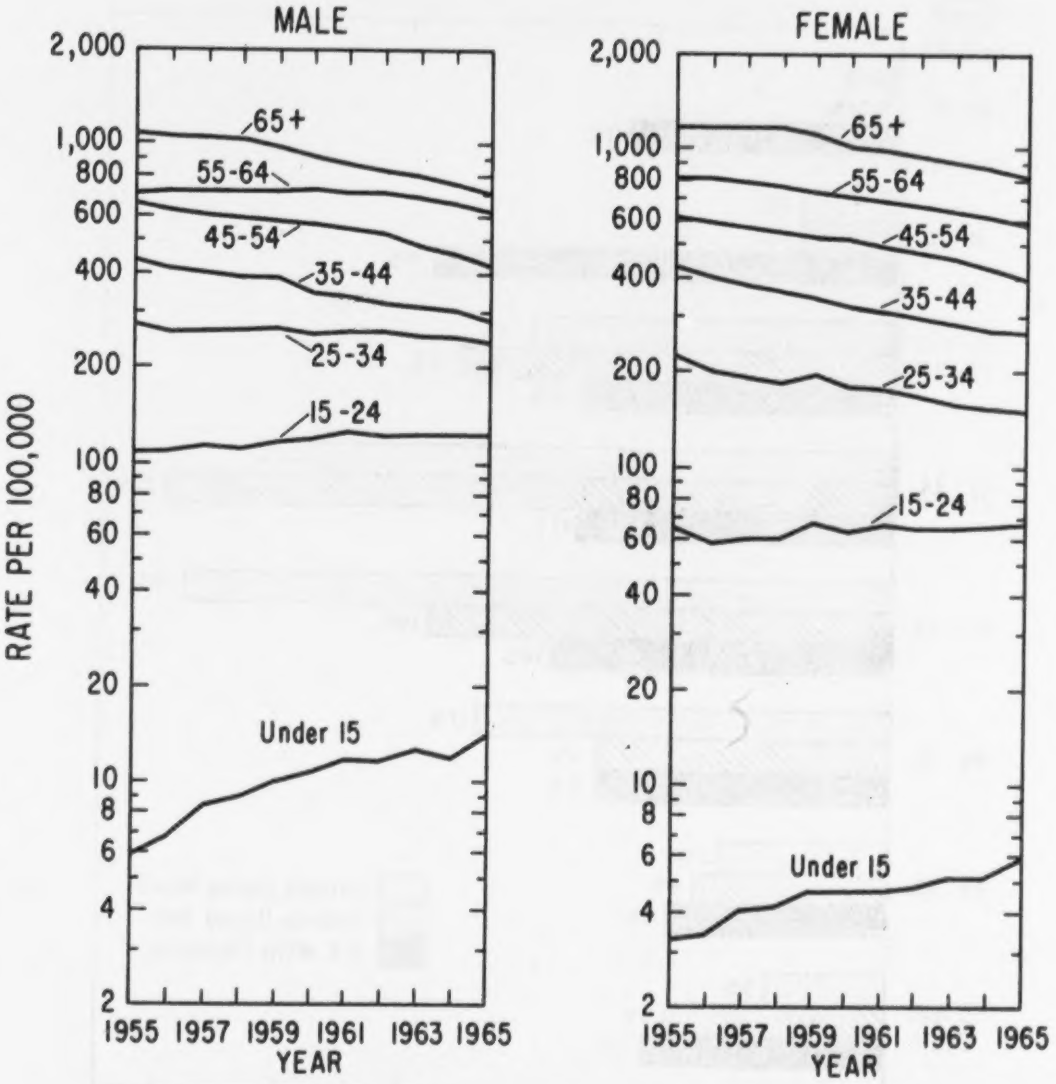
MEDIAN NUMBER OF PERSON-INTERVIEWS RECEIVED BY TREATED PATIENTS, BY AGE AND SEX AND BY DISPOSITION AND SEX, ADOLESCENT PATIENTS TERMINATED FROM 788 OUTPATIENT PSYCHIATRIC CLINICS, U.S., 1962



Source: Adolescent Patients Served in Outpatient Psychiatric Clinics (Figure 5) by B. M. Rosen, A. K. Bahn, R. Shellow and E. M. Bower. American Journal of Public Health 55: 1563-1577, October 1965.

FIGURE 12

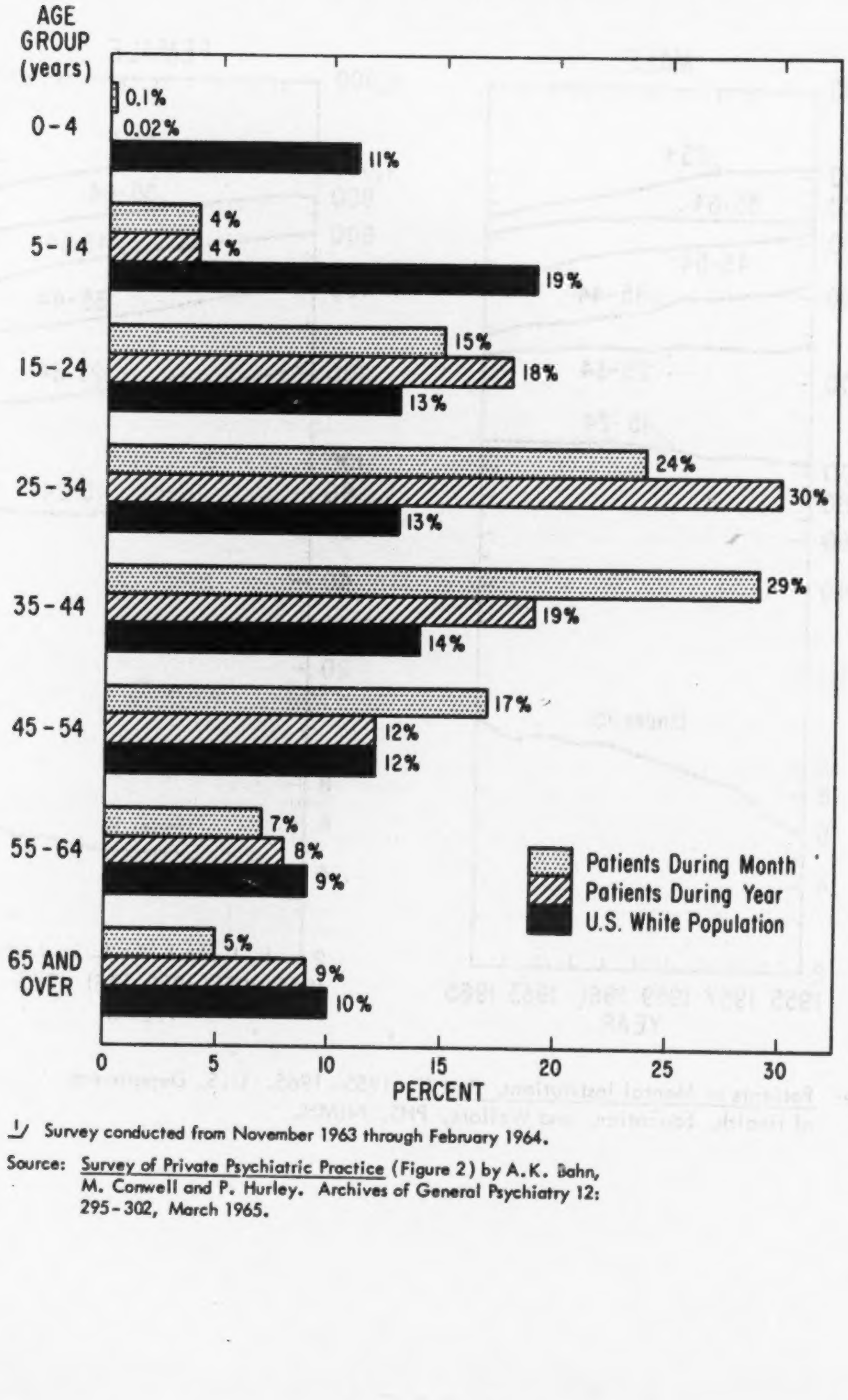
RESIDENT PATIENTS, PER 100,000 POPULATION, END OF YEAR, IN STATE AND COUNTY MENTAL HOSPITALS, BY AGE AND SEX, UNITED STATES, 1955-1965



Source: Patients in Mental Institutions, Part II, 1955-1965. U.S. Department of Health, Education, and Welfare, PHS, NIMH.

FIGURE 13

PERCENTAGE DISTRIBUTION OF PRIVATE PATIENTS SEEN DURING A SAMPLE MONTH AND ESTIMATED FOR THE YEAR BY AGE, COMPARED WITH UNITED STATES WHITE POPULATION [1]



[1] Survey conducted from November 1963 through February 1964.

Source: Survey of Private Psychiatric Practice (Figure 2) by A.K. Bahn, M. Conwell and P. Hurley. Archives of General Psychiatry 12: 295-302, March 1965.

SPECIAL STUDIES HIGHLIGHTING UTILIZATION PATTERNS

UTILIZATION OF SERVICES IN SMALL AREAS

This section will highlight findings from special studies based on data for small areas or individual States. Although utilization patterns of mental health facilities will differ from community to community and State to State depending largely on availability of psychiatric and other mental health services, findings of several studies conducted by or in collaboration with the Biometry Branch may provide some insight into the reasons for differences.

Louisiana–Maryland Socioeconomic Study

In a study of the socioeconomic and family characteristics of patients first admitted to psychiatric services in Louisiana and Maryland in 1960, rates for children were considerably higher in Maryland than Louisiana as a result of the greater availability and use of psychiatric outpatient clinics in Maryland (26) (figure 14). Little difference was noted between the two States in rates for children admitted to public mental hospitals, but in Louisiana unlike Maryland there was a greater use of psychiatric facilities in general hospitals primarily because of the large psychiatric unit at Charity Hospital in New Orleans.

Maryland Psychiatric Case Register

The Maryland Psychiatric Case Register provides unique information on the utilization of psychiatric facilities through the linkage, into a single record, of all episodes of service received by an individual over a specified interval of time. Several other registers currently in existence in the United States are Monroe County, N.Y., Hawaii, and a three-county area in North Carolina (25). Results of a Monroe County register study will be discussed in the section following.

Multiple Use of Facilities (Amount of Duplication)

Information on the multiple use of facilities in Maryland is available by examining the amount of duplication within each type of service, that is, the number of admission actions compared to the number of patients served. Table 9 illustrates that about 1 percent of the 1,600 young children (under 10 years), and about 2 percent of the 3,100 adolescents 10-17 years, used more than one facility during the year ending June 30, 1964 (27). Most of this multiple usage occurred in clinic services.

Length of Stay

Comparisons of length of stay of discharged patients also reveal differences in how facilities are used. As shown in the table below, for example, the median number of months under care in county clinics, which are primarily rural, is generally short compared to that of city clinics. This reflects to some extent the inaccessibility of these rural clinics as well as the use made of such clinics for nontreatment services, such as psychological testing services, which are available in the larger cities through the school system.

Number of Patients and Median Months under Care, 1964

Type of facility	Patients under 5 years of age		Patients 5-14 years of age	
	Number	Months under care	Number	Months under care
Inpatient facilities:				
Public mental hospitals	3	*	64	5
Private mental hospitals	3	*	25	31
General hospitals	0	*	10	12
Outpatient clinics:				
Baltimore City clinics	20	5	374	10
County clinics	25	5	705	6
State hospital clinics	5	*	20	2
D.C. clinics	10	10	305	24

*Too few patients for reliable data.

Recurrent Episodes of Psychiatric Service to Adolescents in Maryland

The utilization of facilities by 5,000 adolescents, during a 3-year period, was examined in a recent study based on the Maryland Psychiatric Case Register (28). Seventy-seven percent of these adolescents were seen in outpatient facilities only, 13 percent were inpatients only, and 9 percent received both types of care (table 10). Fifteen percent of the adolescents had multiple admissions. These included a relatively high proportion of patients who were hospitalized, children with psychosis or brain syndromes, and referrals from social or welfare agencies.

An unexpected finding concerned the disposition of the patient's case following his first admission. Approximately the same proportion of cases was discharged with a disposition of "further care not indicated" whether this was the first of several admissions or the only admission in this period (30 percent). Such a finding would suggest the need for a study of the treatment and discharge policies of psychiatric facilities involved.

Monroe County, New York, Psychiatric Case Register

Data from the Monroe County Psychiatric Case Register are of particular interest because they are collected not only from psychiatric facilities but from private psychiatrists (25). Seven percent of the 570 children under 15 years of age admitted to psychiatric care were seen in private psychiatric practice. Over 90 percent were seen in outpatient clinics. One-tenth of the children seen in private practice were seen in other psychiatric facilities also.

RELATIONSHIP OF HOUSEHOLD FACTORS TO PATTERNS OF CARE FOR MENTAL ILLNESS

Louisiana–Maryland Socioeconomic Study

Research on the etiology and the ecology of mental illness has stressed the importance of family characteristics and living arrangements on the risk of needing psychiatric care.

The socioeconomic study previously mentioned attempted to identify segments of the population having a high risk of psychiatric admissions (29). Records on admissions to all psychiatric facilities in Louisiana and Maryland, during the year following the 1960 census, were matched against census schedules so that data on family characteristics, income, occupation, etc., were available. Several findings specific for children were consistent in both States:

(1) Rates for children in husband-wife families decreased with increasing family size (figures 15, 16).

(2) Rates for children in "other male" families were unusually high in families of size 2 (no mother) and in those of six or more members.

(3) Rates for children of female-head families were unusually high in families of size 2 (no father) in Louisiana. In Maryland, rates for children of female-head families were twice as high as rates for husband-wife families, regardless of size of family (families of size 2 excluded).

(4) Although most children were first admitted to outpatient services, a relatively larger proportion in lower income families tended to go to State mental hospitals (figure 17).

Baltimore Ecology Study

A study stemming from the Maryland register on the ecology of diagnosed mental illness in Baltimore indicated a positive association between high psychiatric admissions and such factors as adult crime, juvenile delinquency, unemployment, poor housing, low educational and occupational attainment, and children not living with both parents (30).

Table 9

Duplicated and Unduplicated Counts of Children Who Are Maryland Residents Admitted to Psychiatric Facilities, July 1, 1963 - June 30, 1964

Type of facility	Duplicated - Number of admission actions		Unduplicated (within each type of facility) - Number of patients served within each type of facility	
	Under 10 years	10-17 years	Under 10 years	10-17 years
All facilities	1,661	3,165	1,639	3,101
All inpatient facilities	128	641	128	621
Public mental hospitals	113	458	113	450
Private mental hospitals	10	80	10	76
General hospitals	5	103	5	95
Outpatient clinics	1,533	2,524	1,511	2,480
Baltimore City clinics	408	637	400	628
County clinics	864	1,611	852	1,582
State hospital clinics	197	203	195	198
D. C. clinics	64	73	64	72

Source: Maryland Psychiatric Case Register Statistical Series, Annual Tables for Year Ended June 30, 1964, Series A-II, B-II. U.S. Department of Health, Education, and Welfare, PHS, NIMH and Maryland State Department of Mental Hygiene.

Table 10

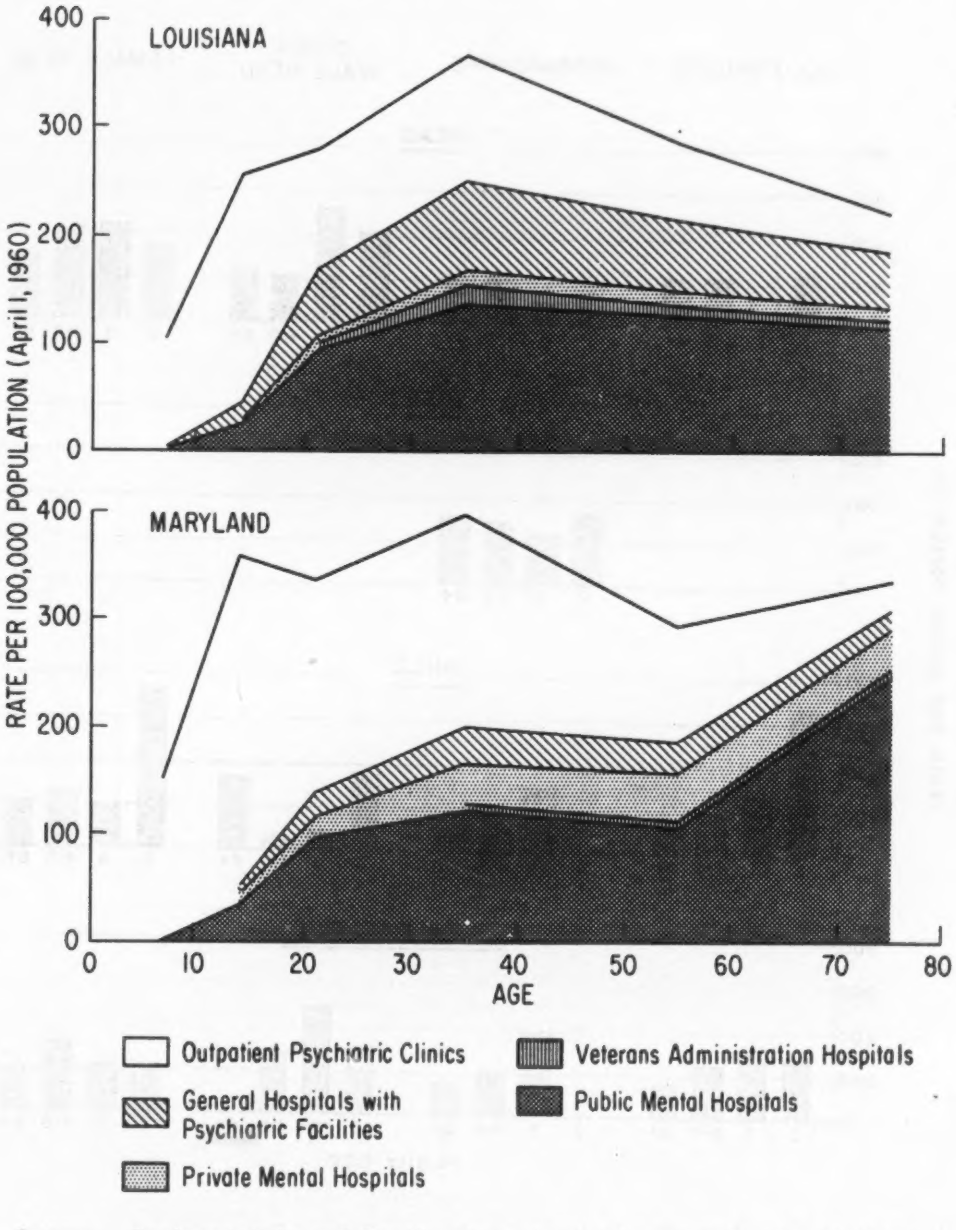
Use of Maryland Psychiatric Facilities by Adolescents, 10 to 17 Years of Age, July 1, 1961 - June 30, 1964, According to Number of Admissions and Length of Time Between Episodes.

Type of facility	All Groups	Number Of Admissions					
		One Admission				Multiple Admissions	
		Undercare June 30, 1964		Terminated prior to June 30, 1964		Longest Interval between a Termination and Next Readmission	
		Duration of Admission		Duration since Termination			
		365 days or less	366 days or more	365 days or less	366 days or more	92 days or less	93 days or more
Total number of patients	5,109	627	294	1,260	2,137	349	442
Percent distribution	100	100	100	100	100	100	100
Inpatient only	13	15	31	14	9	18	9
One facility	12	15	31	14	9	10	3
Multiple facilities	1	-	-	-	-	8	6
Outpatient only	77	85	69	86	91	11	39
One facility	77	85	69	86	91	9	36
Multiple facilities	.4	-	-	-	-	2	3
Both types of service	9	-	-	-	-	71	52
Outpatient - inpatient	7	-	-	-	-	50	42
Inpatient - outpatient	2	-	-	-	-	21	10

Source: Recurrent Episodes of Psychiatric Service in an Adolescent Population by A.K. Bahn and M.S. Oleinick, NIMH, July 1966.

FIGURE 14

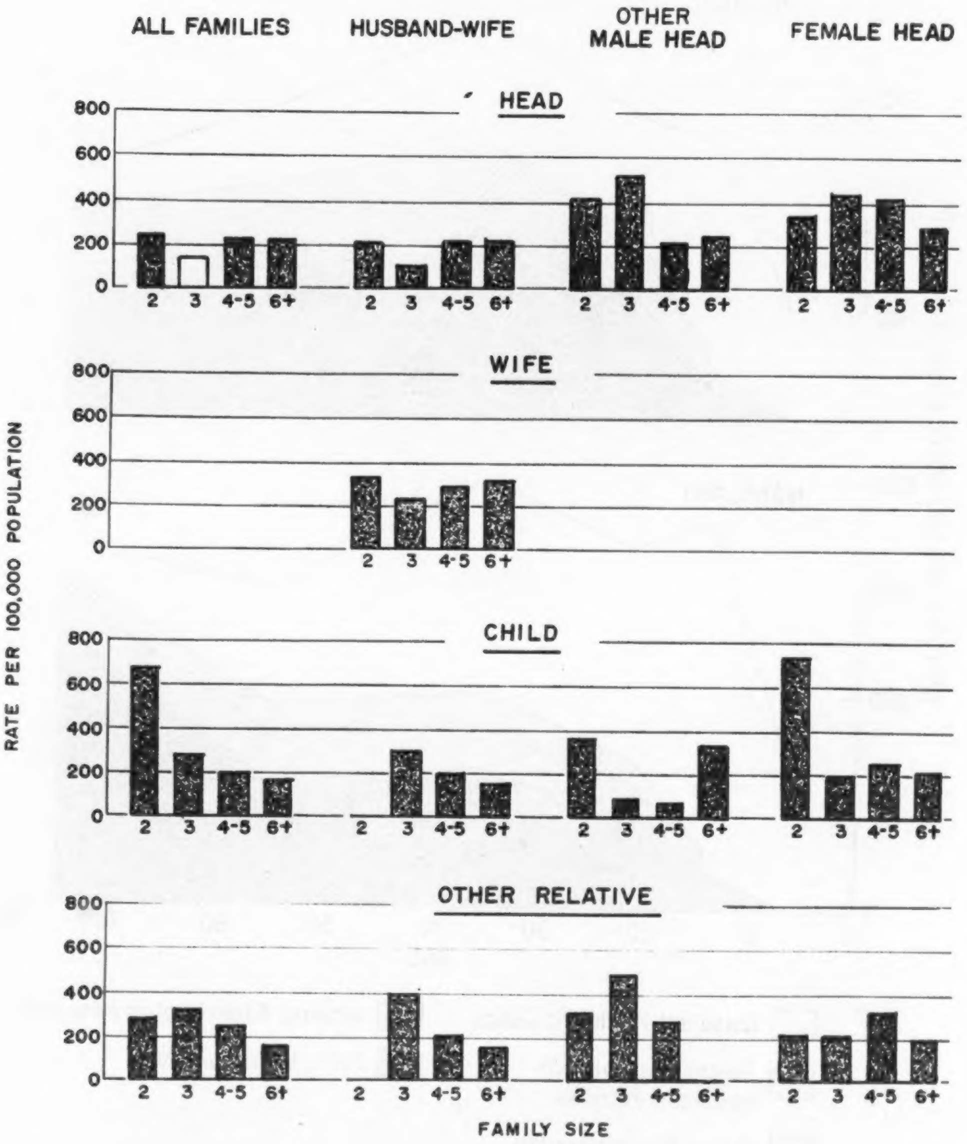
FIRST ADMISSION RATES TO PSYCHIATRIC FACILITIES BY TYPE OF FACILITY
LOUISIANA AND MARYLAND, 1960-1961



Source: Socioeconomic and Family Characteristics of Patients Admitted to Psychiatric Services (Figure 2) by E. S. Pollack, R. W. Redick, V. B. Norman, C. R. Wurster and K. Gorwitz. Amer. J. of Public Health 54: 506-518, March 1964.

FIGURE 15

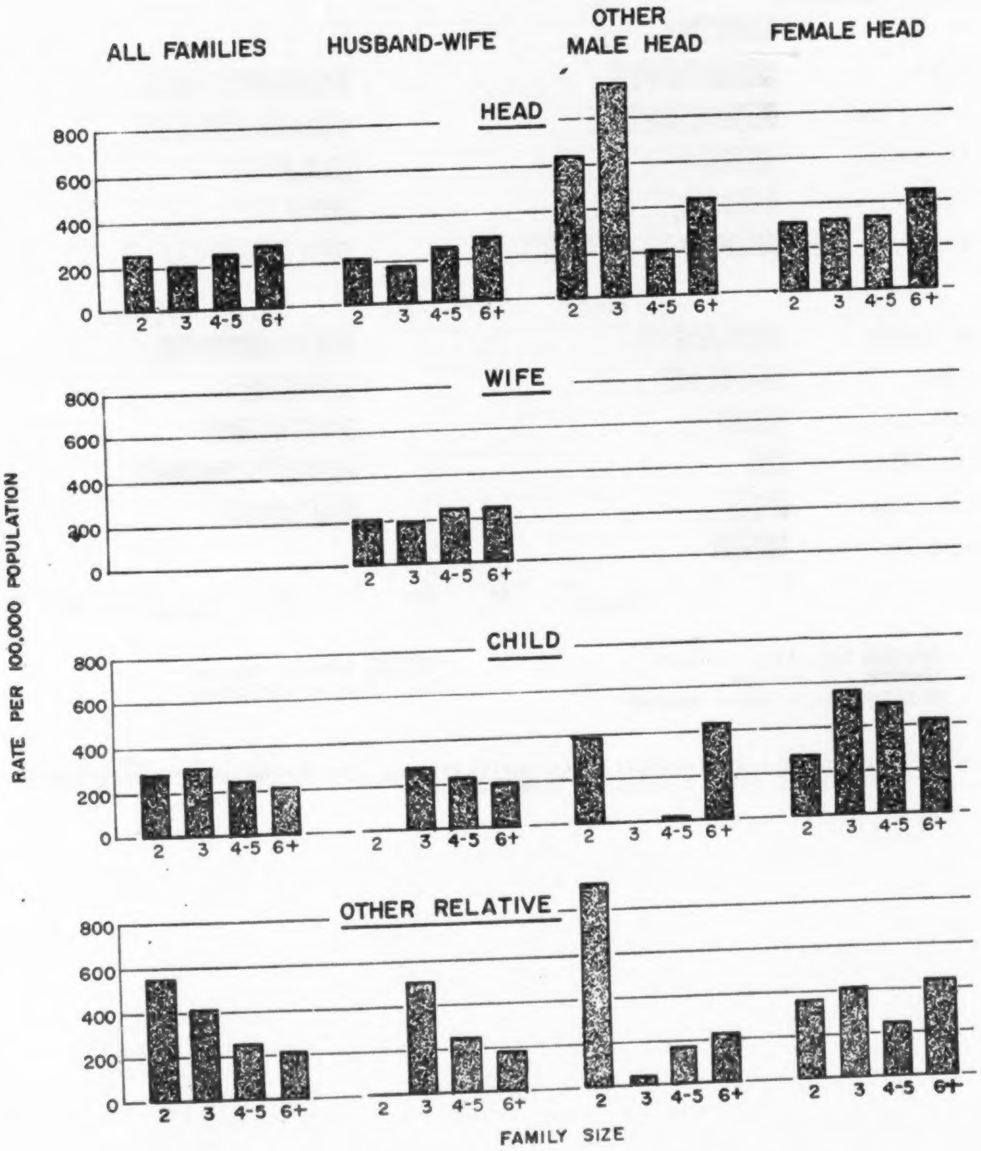
AGE-ADJUSTED FIRST ADMISSION RATES BY FAMILY RELATIONSHIP, FAMILY SIZE, AND TYPE OF FAMILY
LOUISIANA, 1960-61



Source: Monitoring a Comprehensive Mental Health Program: Methodology and Data Requirements (Figure 2) by E. S. Pollack. NIMH, June 1966.

FIGURE 16

AGE-ADJUSTED FIRST ADMISSION RATES BY FAMILY RELATIONSHIP, FAMILY SIZE, AND TYPE OF FAMILY MARYLAND, 1960-61

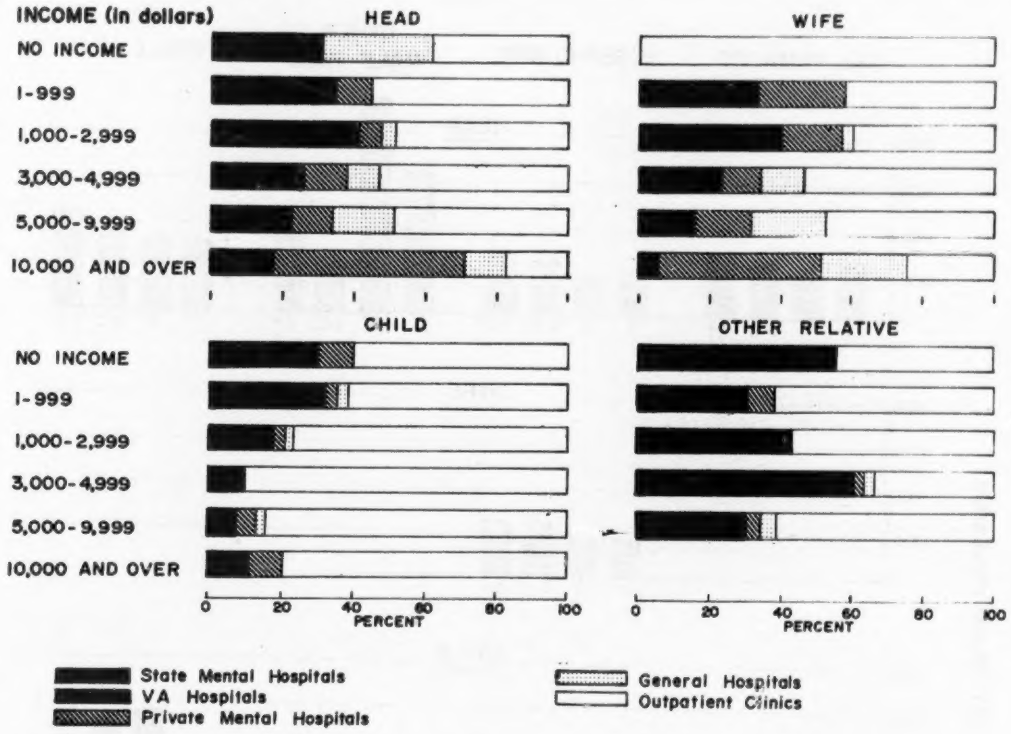


Source: Monitoring a Comprehensive Mental Health Program: Methodology and Data Requirements (Figure 3) by E. S. Pollack. NIMH, June 1966.

FIGURE 17

FIRST ADMISSIONS TO PSYCHIATRIC FACILITIES BY FAMILY RELATIONSHIP AND INCOME OF FAMILY HEAD

PERCENT DISTRIBUTION BY TYPE OF FACILITY, MARYLAND, 1960-61



Source: Monitoring a Comprehensive Mental Health Program: Methodology and Data Requirements (Figure 18) by E. S. Pollack. NIMH, June 1966.

TABLE 11

Characteristics of Adolescents, 12 to 17 Years of Age, Receiving Services in a Maryland Psychiatric Facility and/or Social Work Services in the Baltimore School System (Division of Special Services)

Family Data: Selected Disruptive Familial Factors

Category	Division of Special Services Cases	
	Also Psychiatric Cases on Maryland Register	Non Psychiatric Cases - Control Group
Number of Cases	140	177
Percent Distribution:		
Number of disruptive factors:	100	100
None	25	27
One	20	29
Two	17	23
Three	19	8
Four or more	19	13
Selected disruptive factors:	#	#
Poverty	17	22
Physical illness - Mother	7	9
Father	3	4
Mental illness - Mother	11	3
Father	7	2
Alcoholism - Mother	4	2
Father	11	6
Crime - Mother	.7	.6
Father	9	3
Sibling	9	4
Neglect - Mother	9	6
Father	9	6
Conflict - General	8	5
Regarding child	4	5
Physical abuse	6	5
Rejection	12	10
Parent inadequate, etc.	8	1

# Does not add to 100 percent, since more than one disruptive factor may be present.

Source: Characteristics of Adolescent Cases Receiving Psychiatric Services and/or School Facility Services by M.S. Oleinick and A.K. Bahn, NIMH, July 1966.

TABLE 12

Characteristics of Adolescents, 12 to 17 Years of Age, Receiving Services in a Maryland Psychiatric Facility and/or Social Work Services in the Baltimore School System (Division of Special Services)

Family Data: Living Arrangements

Category	Division of Special Services Cases: Also Psychiatric Cases on Maryland Register	Division of Special Services Cases: Non Psychiatric Cases - Control Group
Total Number of Cases	140	177
Percent Distribution:		
Parental marital status:	100	100
Married	47	52
Separated	16	10
Divorced	4	3
Widowed	9	10
Never married	3	3
Mother and stepfather	19	21
Other	2	1
Maternal employment:	100	100
Housewife	54	64
Part-time employed	15	6
Full-time employed	31	30
Living with father:	100	100
Natural	44	50
Stepfather	17	21
None	29	22
Other	10	7
Living with mother:	100	100
Natural	86	92
Other	14	8
Number of changes in living arrangements:	100	100
None or one	32	48
Two or more	68	52
If change in living arrangement, major portion of time with:	100	100
No change	22	34
Mother and father	36	26
Mother only	16	16
Mother and stepfather	12	17
Other	14	7

Source: Characteristics of Adolescent Cases Receiving Psychiatric Services and/or School Facility Services by M.S. Oleinick and A.K. Bahn, NIMH, July 1966.

IMPLICATIONS AND DISCUSSION

This report has presented data on patterns of care of children under 18 years of age in psychiatric facilities as derived from the annual reporting program and special studies conducted by the Biometry Branch of the National Institute of Mental Health. The special studies cited for a State or community provide supplementary information which might help to explain these utilization patterns. No attempt is made here to provide an exhaustive compendium of research in the areas covered but only to consolidate the findings of the Biometry Branch. These special studies should be interpreted with this limitation in mind.

This section will deal with the implications of these findings for planning and administration of mental health programs and for conducting research on the prevalence, etiology, and ecology of mental illness.

SEX DIFFERENCES

Of the almost half-million children under care during 1966, about 300,000, or about 65 percent, were boys. A sex ratio of approximately two boys to one girl was prevalent in clinics and public mental hospitals, the facilities providing service to 90 percent of the children. Further, boys remained in hospitals longer. These findings raise a number of questions on factors associated with these differential patterns of care which suggest areas for further research. Is there a true difference in incidence of emotional disorder by sex, or do the "acting out" behavior patterns of boys cause their parents and community agencies to seek help more frequently? Do as many girls suffer from emotional disorders but receive help from nonpsychiatric agencies? What other factors contribute to this pattern? Why are so many more boys than girls treated in public mental hospitals and outpatient psychiatric clinics than in private mental hospitals and general hospitals? Is the predominance of certain disorders for each sex in each facility (psychoneurosis among girls and personality disorders among boys) due to true incidence, a reflection of diagnostic bias, or other factors? Why does the sex ratio change after childhood and adolescence in outpatient clinics where rates are higher for young women 20-34 years than for young men? What implications do the sex differences in utilization patterns, both among children and adults, have toward the development of adequate case-finding and treatment services (table 13)?

DIFFERENCES IN UTILIZATION PATTERNS AMONG PSYCHIATRIC FACILITIES

Comparisons of the similarities and differences in utilization patterns by age, sex, and diagnosis among different types of psychiatric facilities can provide insight into their varying roles in the care of mentally ill children and adolescents.

Major findings are:

(1) In each type of facility, there were relatively more boys than girls with personality disorders (except younger boys in general hospitals) and more girls than boys with psychoneurotic disorders.

(2) Transient situational personality disorders were predominant in clinics for all children and in inpatient facilities for adolescents.

(3) Schizophrenic reactions, particularly among adolescents, and brain syndromes, were considerably more important in inpatient facilities than in outpatient clinics.

(4) There was a somewhat higher proportion of younger patients with personality

disorders in private mental hospitals in contrast to the lower percent with situational disorders in these facilities. In all other types of facilities the distribution is reversed. The difference may be more one of diagnostic practice than pathology.

Another finding of significance is the extremely high proportion of brain syndrome cases in the under 10-year age group in general hospitals. This reflects the ready accessibility of the hospital, particularly for emergencies, the ability of the general hospitals to serve such cases, and the probability that the general practitioner and pediatrician are treating these patients.

The high proportion of undiagnosed patients seen in clinics compared to the relatively few in hospitals is also of interest (tables 3a, 3b, 3c). This reflects various factors: the kind of children who come to clinics, the reluctance of the clinic psychiatrist to "label" a patient, the inadequacy of the diagnostic classification for many children's disorders, the brief service provided to many patients, the use of clinics as an evaluation and testing service, and, also, the admittance practices in hospitals. Unlike clinics where patients are not necessarily assigned a diagnosis until termination (and sometimes not even then), a diagnosis is usually required at admission to a hospital, particularly to a general hospital where insurance benefits demand this.

Further investigation is needed to determine to what extent the selection of the psychiatric facility reflects true need, or merely availability. For example, the admission and treatment policies of a facility may exclude certain patients who will in turn seek the "next best" care or none at all. Available data show that services for children are limited or not provided in many facilities. Of the more than 2,000 clinics open in 1965, approximately 80 percent served children while the remainder were open only to adults. According to a recent survey of the State mental hospitals, 39 provided separate units for children, and an additional 76 provided children's services but did not have any special programs for this age group. Of the approximately 150 private residential treatment centers for children in operation in 1965 (33), most could serve only a small caseload (an average of 55 children in each) and many were extremely costly (34, 35).

Coordination of various types of psychiatric services on a community level is of considerable importance today in providing for effective utilization of available resources. The movement toward the establishment of community mental health centers and other community-based services emphasizes this need. In addition, followup studies to determine what happens to children who receive psychiatric services are urgently needed to provide some basis for evaluation of psychiatric programs.

LIVING ARRANGEMENTS AND HOUSEHOLD COMPOSITION, CENSUS DATA

The National Institute of Mental Health studies on household composition suggest a correlation between chance of admission to a psychiatric facility and living arrangements. Because of the influence of a depersonalized or disruptive environment on the demands for mental health services, it is important to consider some data for two groups of children living under inadequate family situations, those living in institutions and those living in broken homes.

Institutional Population

According to the 1960 U.S. Census, 238,000 children under 18 years lived in institutions (36) (figure 18). Data on color emphasizes marked differences in the kinds of institutions occupied by white and nonwhite children. For example, 60 percent of the institutionalized white children lived either in facilities for the mentally handicapped or in homes for dependent children, while only 36 percent of the nonwhite children lived in these types of institutions. On the other hand, 18 percent of the white children who were institutionalized lived in training schools for juvenile delinquents or other correctional facilities in contrast to 40 percent of the nonwhite children. These findings suggest that there may be vast inequities in the way in which behavior problems of children from different social and racial backgrounds are handled.

Children Living in One Parent or No Parent Homes

In 1960, 92 percent of the white children under 14 years, but only 68 percent of the nonwhite children in this age group, lived with both parents (37) (table 14). Of the more than 6,000,000 children under 14 years living apart from at least one parent, more than 1,600,000 lived with neither parent, and about 4,500,000 lived with one parent. Of those not living with both parents, a slightly higher proportion of white children than nonwhite lived with their father only, while relatively more nonwhites than whites lived with neither parent.

The occurrence of broken homes appears to be increasing. Data available for 1960 and 1966 on family arrangements for children under 18 years indicate that, in 1960, 25 percent of the nonwhite children and 8 percent of the white children under 18 did not live with both parents; in 1966, the percents were 29 and 9, respectively (38).

Mental Illness, Color, Poverty

The correlation between the risk of a psychiatric admission and environmental factors associated with living in a poverty area, that is, high proportion of disruptive families, juvenile delinquency, adult crime, poor housing, and inadequate education, has been shown. Mental health administrators are faced with difficult problems in developing programs to prevent and control mental illness among persons living in "poverty" areas. These problems are particularly intense for the nonwhites. Data show that 62 percent of all nonwhite families lived in poverty areas in 1966 (38). In terms of income, 35 percent of the nonwhite families had incomes below the poverty level (less than $3,000 per year) compared to only 10 percent of the whites.

Although no hospital data for children, by color, are available nationwide, a 13-State Biometry Branch collaborative study (MRA Cohort Study) showing first admission rates to State mental hospitals, by age, color, and sex during 1960, indicated that for nonwhite children, schizophrenia admission rates were about three times as high as the corresponding rates for white children (39). Similarly, outpatient data indicate that rates for nonwhite children were higher than those of white children but only for the more serious disorders. Clinic data also indicate that nonwhite children are more likely to receive clinic care when they are older. These findings point up the critical need for effective methods for prevention, early case-findings, and meaningful treatment programs directed toward poverty and culturally deprived groups.

SUICIDE

In considering the impact of various social factors on the development of effective mental health programs, consideration must be given to the increasing suicide rate in the group 15-24 years of age during the last decade (figures 19a, 19b). Suicide prevention programs designed for adolescents and college age persons must be developed to counteract this rising trend.

IMPACT OF FEDERAL AND STATE PROGRAMS ON PATTERNS OF CARE AND LENGTH OF STAY IN INPATIENT FACILITIES

Only limited data from various States are available on the length of time under care and type of service a child receives in a hospital setting. Data on number of patients and median months of care, previously presented in this report, provide a comparative picture for Maryland for 1 year. The probability of being released within a specified time span is dependent on many factors, such as admission policies of the hospital, patient characteristics, and suitable outpatient programs for "aftercare" as well as the kinds of programs provided in the hospital for children. For example, a new Federal educational program provides for funds to establish such programs for handicapped children (40). Similarly, the NIMH's Hospital Improvement Grant Program, focusing on improved services in State mental hospitals, also provides for educational services for children (41). Such programs established in a mental hospital may have the effect of prolonging hospital care.

Data on length of stay from the MRA Cohort Study of patients admitted to State mental hospitals from July 1, 1959, through June 30, 1960, indicate differences, by color and sex, in length of time under care among children hospitalized for schizophrenia (39) (appendix table 14). Forty percent of the children under 15 years were still in the hospital 1 year after admission, compared to 18 percent of those 15-24 years of age. In general, a larger proportion of boys than girls, in both age groups, and relatively more whites than nonwhites, particularly among the younger children, remained in the hospital after 1 year.

On the other hand, a recent report for 14 Southern States providing data for all hospitalized children, by color and length of stay in mental hospitals, indicated that the nonwhites remained somewhat longer than the whites (42). Data from this report and from California showed that for a number of these States the median length of hospitalization was greater for younger children than for older ones (43). According to Dr. Harold L. McPheeters of the Southern Regional Education Board, the variability reflected by data from individual States reflects not only differences in the availability of programs specifically for children but, to some extent, the differences in philosophy concerning provisions of services for children (42). Some believe that children should not be hospitalized, while others feel that hospital treatment should be long term. Some experts believe that children should be hospitalized in separate hospitals, while others consider it preferable to mix young people in with adults because this provides a more normal family-like structure.

In spite of these philosophical differences, nationwide trend data indicate that the number of youths receiving care in State mental hospitals is continuing to increase in spite of current emphasis on reducing the mental hospital patient population (44, 45). Not only are admission rates increasing but resident patient rates as well. These trends will continue unless steps are taken to develop more effective prevention and early treatment programs.

CURRENT AND PROJECTED MENTAL HEALTH PROGRAM NEEDS

Estimated Needs: School Studies

Discussion in this report has focused primarily on current utilization patterns of psychiatric facilities, not on incidence or prevalence of mental illness among children.

Various surveys conducted through school systems provide us with some estimates of how many children may really need mental health care. Several of these surveys indicated that approximately 2 to 3 percent of the school children were in need of psychiatric care and an additional 7 percent in need of some help for emotional problems (46, 47, 48). Other estimates have ranged from 7 to 12 percent (49).

How easily and accurately can these children be identified? A study by Bower, et al., on school characteristics of male adolescents who later became schizophrenic suggests that these boys were significantly different from a randomly selected control group of peers (50). Preschizophrenic boys tended to have less interest in girls, group activities and athletics, showed less leadership skills, and were more submissive, anxious, dependent and careless than the average boy.

Such findings have far reaching implications. The school is in an extremely strategic position to provide systematic case-finding services. If, in fact, it can identify children who later become seriously disturbed, organized case-finding programs can be developed to detect incipient mental illness. Such programs, however, must be coupled with effective treatment services.

Current Needs

If we assume the conservative figure of 2 percent, as cited above, 1,400,000 children needed psychiatric care in 1966 (51). Our estimate indicates that less than 500,000, or only a third, received such care.

Projected Needs

If current patterns and trends in the utilization of psychiatric clinics and mental hospitals continue, it is estimated that, by 1975, approximately 1,200,000 children will receive care in a psychiatric facility, 900,000 in clinics, the remainder in hospitals.

In terms of estimated needs, however, the picture is quite different. By using a conservative population projection (51), in 1975, there will be 77,845,000 children under 18 years of age (appendix table 15). Minimally (2 percent in need), 1,500,000 children will require help in 1975. Assuming a 7 percent estimate of needs, almost 5,500,000 children will need help. For a 12 percent estimate, more than 9,000,000 will need help.

Manpower Projections

An estimate of expected manpower resources can provide a realistic appraisal of potential ability to provide needed services. Projections are available on manpower in the mental health care professions for 1968-1972 based on training programs, estimates made by various professional groups, attrition, etc. (52). If we assume that current manpower and utilization patterns continue (see appendix 16 for assumptions and method), by 1972, almost 15 percent fewer mental health core professionals will be available than the expected demand for service. In short, we will not be able to provide the current level of service in the near future. This expected dearth of services may be even greater for children than adults. Considering only clinics, where most children are served, children receive less service in terms of time than adults because only a third receive treatment compared to more than half of the adults (9).

Underlying these manpower projections is an assumption that current levels of service, that is, the ratio of available manpower to patient population, should be maintained. To evaluate this assumption we can consider the goals stated in 1961 by the Joint Commission on Mental Illness and Health for clinic programs–two full-time professional clinic teams or 280 man-hours per week per 100,000 population (53). In 1965, only 221 man-hours per 100,000 patients were provided. For hospital patients, in 1965, there was a ratio of one mental health professional to 30 patients. However, the ratios of one physician for 30 patients in admission or intensive care, and one registered nurse, one psychologist, and one social worker for each 40 patients are considered minimal, according to another report of the Joint Commission on Mental Illness and Health (54). Using this as a guide, instead of one mental health professional for each 30 patients, we should have three to four. These data clearly indicate that our present level of service is considerably below recommended goals.

TABLE 13

Ratio of Male to Female Rates Per 100,000 Population for Patients Under Care, Total Admissions, & Resident Patients By Type of Psychiatric Facility, By Age, United States 1966

PATIENTS UNDER CARE

Age	Total All Facilities	Public and Private Mental Hospitals				Outpatient Clinics	State, County & VA
		Total	State & County	Private	General Hospital		
Total	1.19	1.35	1.13	0.64	0.71	1.30	1.47
Under 15	2.05	2.13	2.20	1.56	1.05	2.11	2.22
15-24	1.18	1.66	1.77	1.00	0.73	1.19	1.86
25-34	0.98	1.62	1.49	0.55	0.61	0.83	1.92
35-44	1.18	1.71	1.17	0.57	0.68	1.06	1.97
45-54	1.19	1.39	1.12	0.62	0.76	1.28	1.51
55-64	1.14	1.25	1.16	0.69	0.86	1.14	1.32
65+	1.12	1.18	0.95	0.60	0.88	1.14	1.23

TOTAL ADMISSIONS

Age	Total All Facilities	Public and Private Mental Hospitals				Outpatient Clinics	State, County & VA
		Total	State & County	Private	General Hospital		
Total	1.10	1.39	1.29	0.63	0.71	1.26	1.67
Under 15	2.01	1.88	1.99	1.35	1.05	2.12	2.01
15-24	1.13	1.57	1.69	0.98	0.73	1.19	1.79
25-34	0.89	1.42	1.43	0.53	0.61	0.79	1.79
35-44	1.05	1.64	1.24	0.57	0.68	0.96	2.10
45-54	1.07	1.44	1.24	0.62	0.76	1.12	1.75
55-64	1.03	1.23	1.31	0.68	0.86	1.09	1.46
65+	1.05	1.20	1.17	0.63	0.88	1.09	1.35

RESIDENT PATIENTS

Age	Total All Facilities	Public and Private Mental Hospitals				Outpatient Clinics	State, County & VA
		Total	State & County	Private	General Hospital		
Total	1.32	1.33	1.03	0.69	0.72	1.34	1.35
Under 15	2.12	2.48	2.54	2.29	1.11	2.11	2.54
15-24	1.29	1.87	1.93	1.08	0.73	1.19	1.99
25-34	1.15	2.02	1.59	0.67	0.61	0.88	2.11
35-44	1.42	1.80	1.11	0.55	0.67	1.18	1.85
45-54	1.37	1.35	1.06	0.64	0.76	1.47	1.37
55-64	1.25	1.27	1.12	0.72	0.86	1.20	1.28
65+	1.17	1.17	0.88	0.52	0.88	1.19	1.19

Source: Based on data to be published in Patients in Mental Institutions 1966 Parts II and III and Outpatient Psychiatric Clinics - Data on Patients 1966 and data published in Annual Report - Administrator of Veterans Affairs 1967.

Table 14

Total Number and Percent Distribution of Persons under 14 Years of Age According to Family Status and Presence of Parents, by Age and Color, United States, 1960

Family status and presence of parents	White				Nonwhite			
	Total Under 14 years	Under 6 years	6-9 years	10-13 years	Total Under 14 years	Under 6 years	6-9 years	10-13 years
Total number (in thousands)	45,094	20,747	12,669	12,278	7,351	3,532	2,035	1,784
Percent distribution	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
A) Living with both parents	91.9	93.3	91.8	89.5	67.7	69.1	67.4	65.4
1) In primary families 1/	91.9	93.3	91.8	89.5	67.6	69.0	67.4	65.4
a) Father is head	90.8	91.5	91.0	89.0	65.4	65.6	65.9	64.5
b) Grandparent is head	1.0	1.6	0.7	0.4	1.8	2.7	1.2	0.7
c) Uncle or aunt is head	0.1	0.1	0.1	0.1	0.2	0.3	0.2	0.1
d) Other relative is head	0.0	0.1	0.0	0.0	0.2	0.4	0.1	0.1
2) In secondary families 1/	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0
B) Living with father only	0.8	0.6	0.9	1.2	1.8	1.4	1.9	2.4
1) In primary families 1/	0.8	0.6	0.9	1.2	1.8	1.4	1.8	2.4
a) Father is head	0.7	0.5	0.7	1.0	1.3	0.9	1.4	2.0
b) Grandparent is head	0.1	0.1	0.2	0.2	0.4	0.4	0.4	0.3
c) Uncle or aunt is head	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.1
d) Other relative is head	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2) In secondary families 1/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
C) Living with mother only	5.5	4.7	5.6	6.9	19.6	18.5	20.3	20.8
1) In primary families 1/	5.5	4.6	5.5	6.8	19.4	18.3	20.1	20.6
a) Mother is head	4.4	3.1	4.7	6.1	15.4	13.2	16.7	17.9
b) Grandparent is head	1.0	1.3	0.7	0.6	3.1	4.0	2.7	2.0
c) Uncle or aunt is head	0.1	0.1	0.1	0.1	0.5	0.6	0.4	0.4
d) Other relative is head	0.0	0.1	0.0	0.0	0.4	0.5	0.3	0.3
2) In secondary families 1/	0.0	0.1	0.1	0.0	0.2	0.2	0.2	0.2
D) Living with neither parent	1.8	1.4	1.7	2.4	10.9	11.0	10.4	11.4
1) In primary families 1/	1.2	1.0	1.1	1.5	9.3	9.5	8.8	9.4
a) Grandparent is head	0.7	0.6	0.7	0.8	6.2	6.7	6.0	5.7
b) Uncle or aunt is head	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2
c) Other relative is head	0.5	0.4	0.4	0.6	2.9	2.7	2.7	3.5
2) In secondary families 1/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
3) Secondary individual in household 2/	0.3	0.2	0.2	0.3	0.8	0.8	0.8	0.9
4) In group quarters	0.3	0.2	0.4	0.6	0.8	0.7	0.8	1.1
a) Inmate of institution	0.2	0.1	0.3	0.5	0.3	0.1	0.3	0.6
b) Secondary individual 3/	0.1	0.1	0.1	0.1	0.5	0.6	0.5	0.5

1/ A "primary family" comprises the head of a household and all (one or more) other persons in the household related to the head. All other families are "secondary families"; these comprise groups of mutually related persons such as lodgers or resident employees.

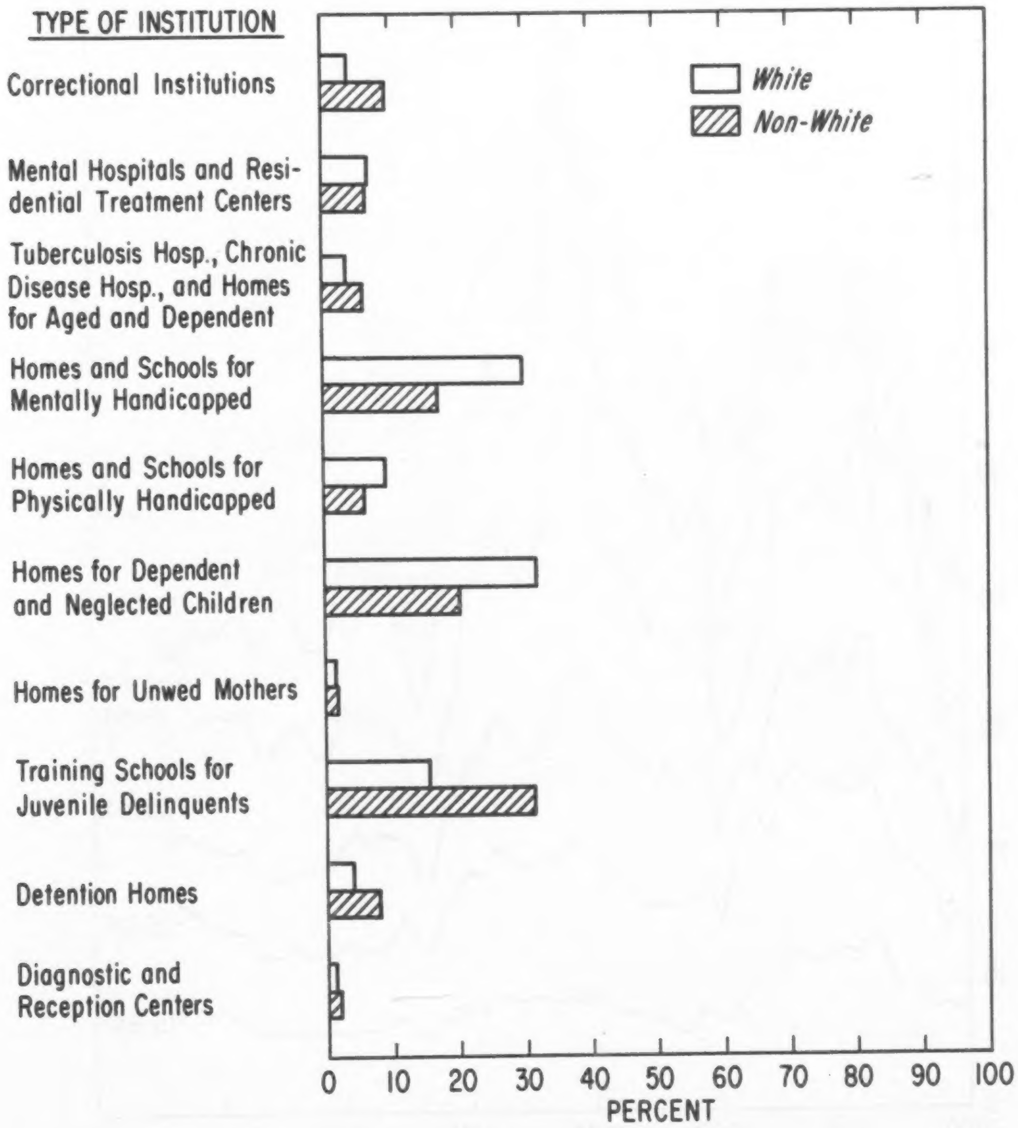
2/ These are essentially children living with foster families.

3/ Children resident in group quarters who are not inmates of institutions.

Source: Persons by Family Characteristics, U. S. Census of Population, Series PC(2) 4B (Table 1). U.S. Department of Commerce, Bureau of the Census.

FIGURE 18

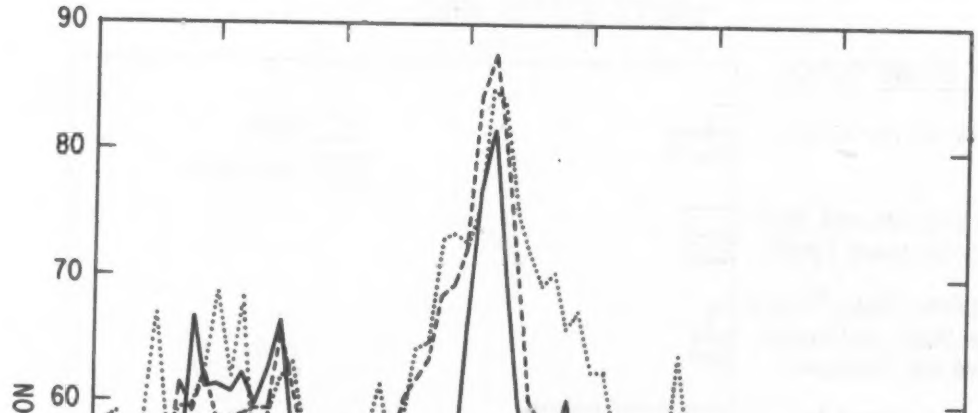
PERCENT DISTRIBUTION OF PERSONS UNDER 18 YEARS OF AGE WHO ARE INMATES OF INSTITUTIONS, BY TYPE OF INSTITUTION AND COLOR, UNITED STATES, 1960



Source: Inmates of Institutions, U.S. Census of Population, Series PC(2)8A (Tables 4-11). U.S. Department of Commerce, Bureau of the Census.

FIGURE 19a

DEATH RATES FOR SUICIDE, BY AGE, FOR MALES, UNITED STATES, 1900-1965 [1]

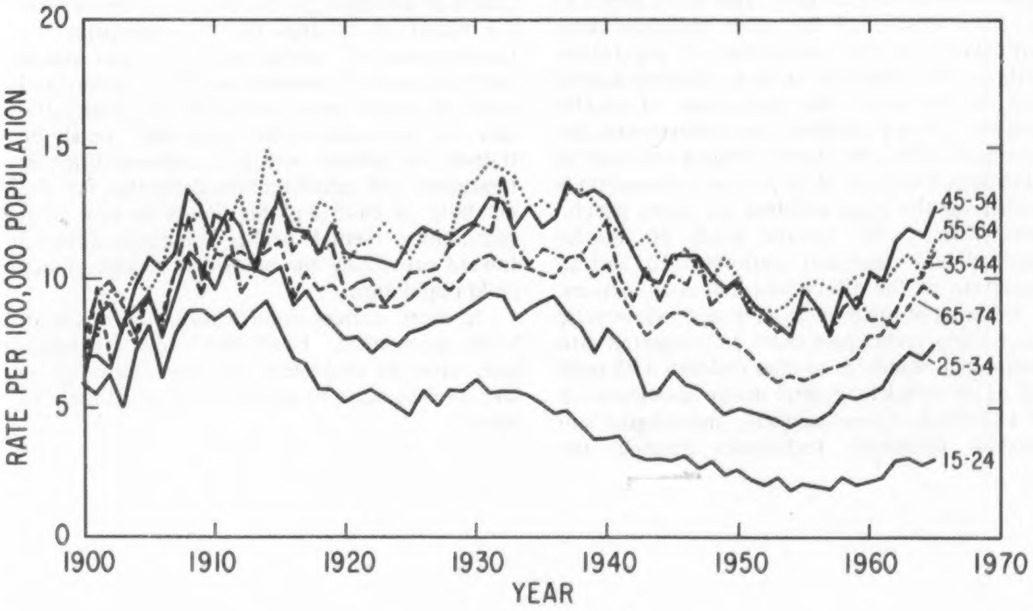


[1] Death rates for age group 85 years and over are not shown.

Source: National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, Public Health Service.

FIGURE 19b

DEATH RATES FOR SUICIDE, BY AGE, FOR FEMALES, UNITED STATES, 1900-1965 1/



1/ Death rates for age groups 75-84 and 85 and over are not shown.

Source: National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, Public Health Service.

CONCLUDING REMARKS

This report presents an overview of psychiatric services to children in the United States and highlights major findings and their implications for program planning. This study serves to emphasize the need for more complete data, particularly on the utilization of psychiatric facilities by minority groups, epidemiological data on incidence and prevalence of mental disorders among children, and information describing specific problems bringing children to psychiatric facilities. More precise information is needed on the ways children are using psychiatric services, the specific kinds of services provided and treatment methods used, and an evaluation of the effectiveness of such services.

In terms of program development, systematic case-finding techniques must be integrated into community resources so that children with both serious or incipient mental health problems can be identified. Concomitantly, meaningful and effective treatment techniques meeting the needs of large numbers of patients from a wide variety of socioeconomic and cultural backgrounds must be developed. The expected dearth in available psychiatric resources to serve the needs of children further emphasizes the requirements of careful definition and assessment of needs to establish realistic priorities and goals. It would seem inevitable that large numbers of nonprofessional personnel must be trained to assume selected responsibilities in treatment and rehabilitation programs for the mentally ill child and his family as well as in community mental health programs directed toward protecting the emotional health of our child population.

In short, current mental health services at all levels–prevention, treatment, and rehabilitation–must be evaluated, and new and imaginative services must be devised to serve all those in need.

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APPENDIX TABLES

Appendix Table 1

Disposition by Age, Total and Treated Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962

Disposition	Total	Age at admission				
		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years
Total number of patients	53,674	12,258	12,083	11,592	9,183	6,558
Percentage distribution:						
Patient or family withdrew	31.2	29.7	28.7	29.3	31.9	41.8
Clinic terminated without referral:						
Further care not indicated	22.1	26.8	23.1	19.6	19.0	20.8
Other	8.2	8.5	8.1	8.5	8.3	6.8
Clinic terminated with referral to:	31.4	28.3	32.6	35.0	32.9	25.7
Inpatient psychiatric facility	5.7	3.7	5.1	5.8	7.3	8.2
Outpatient psychiatric facility, incl. private psychiatrist, day care center	3.4	3.2	3.3	3.0	3.6	4.8
Private physician	1.6	1.9	2.0	1.2	1.3	1.7
Other health agency or medical facility	1.5	2.2	1.5	1.1	1.2	1.4
Social service agency	6.4	5.8	7.2	7.6	6.8	2.6
Court, correctional institution	5.6	2.0	4.7	9.0	7.9	3.7
School	5.6	8.2	7.4	5.9	2.6	1.1
Other (incl. psychological services, clergy, etc.)	1.6	1.3	1.4	1.4	2.2	2.2
Not stated	7.1	6.8	7.3	7.5	7.9	5.0
Number of treated patients	17,795	3,984	3,840	4,017	3,139	2,815
Percentage distribution:						
Patient or family withdrew	39.4	34.0	34.0	39.2	44.0	49.3
Clinic terminated without referral:						
Further care not indicated	32.2	41.1	34.9	30.6	26.6	24.0
Other	8.7	7.8	9.9	9.4	9.0	7.2
Clinic terminated with referral to:	15.8	13.6	17.8	17.0	16.1	15.0
Inpatient psychiatric facility	4.5	2.4	3.9	4.4	5.7	7.1
Outpatient psychiatric facility, incl. private psychiatrist, day care center	2.6	1.7	2.6	2.2	2.8	4.2
Private physician	1.0	1.3	1.4	.7	.8	.8
Other health agency or medical facility	.7	.9	.7	.5	.6	.8
Social service agency	1.9	2.3	2.8	2.0	1.7	.5
Court, correctional institution	1.8	.9	2.0	3.2	2.4	.4
School	2.4	3.3	3.5	3.0	1.0	.2
Other (incl. psychological services, clergy, etc.)	.9	.8	.9	1.0	1.1	1.0
Not stated	3.8	3.2	3.5	3.8	4.1	4.5

Appendix Table 2

Disposition by Major Diagnostic Category, Total and Treated Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962

Disposition	Total	Major diagnostic category								
		Brain syndromes	Mental deficiency	Psychotic disorders	Psycho-physiologic disorders	Psycho-neurotic disorders	Personality disorders	Transient situational personality disorders	Without mental disorder	Undi-agnosed
Total number of patients	53,674	1,766	4,238	2,926	451	5,722	11,960	15,142	1,532	10,637
Percentage distribution:										
Patient or family withdrew	31.2	17.6	8.1	33.3	40.1	37.3	29.7	32.7	8.8	43.3
Clinic terminated without referral:										
Further care not indicated	22.1	16.8	18.8	8.7	21.7	23.5	19.0	29.0	36.9	17.8
Other	8.2	6.7	6.0	6.2	10.0	9.8	9.9	8.7	4.5	6.5
Clinic terminated with referral to:	31.4	53.4	57.5	47.1	22.2	21.6	34.4	23.5	41.7	24.6
Inpatient psychiatric facility	5.7	14.8	11.6	32.2	2.4	4.5	4.5	1.8	.8	2.8
Outpatient psychiatric facility, incl. private psychiatrist, day care center	3.4	4.1	1.6	4.9	3.1	4.9	3.3	2.9	.8	4.3
Private physician	1.6	8.2	1.9	[illegible]	6.2	1.5	1.1	1.1	1.8	1.5
Other health agency or medical facility	1.5	8.0	3.8	[illegible]	2.7	.8	1.0	.8	2.9	1.1
Social service agency	6.4	4.4	12.4	2.6	3.8	3.7	6.3	6.0	22.5	4.9
Court, correctional institution	5.6	2.7	6.1	2.2	1.1	2.5	11.7	5.2	3.7	2.7
School	5.6	8.8	18.3	1.4	2.0	2.4	4.5	4.6	8.2	5.2
Other (incl. psychol. services, clergy, etc.)	1.6	2.4	1.8	1.3	.9	1.3	2.0	1.1	1.0	2.1
Not stated	7.1	5.4	9.6	4.9	6.0	7.7	7.0	6.1	8.2	7.7
Number of treated patients	17,795	658	505	1,219	246	3,120	4,649	7,044	124	230
Percentage distribution:										
Patient or family withdrew	39.4	29.9	24.6	37.4	43.5	41.3	42.2	39.0	25.0	41.3
Clinic terminated without referral:										
Further care not indicated	32.2	22.5	27.3	15.0	32.5	33.0	27.3	38.8	47.6	33.5
Other	8.7	6.5	6.3	7.2	8.1	8.6	11.0	8.0	9.7	5.7
Clinic terminated with referral to:	15.8	38.0	38.6	36.4	12.8	12.1	15.9	10.5	15.3	16.3
Inpatient psychiatric facility	4.5	13.4	12.1	25.6	1.6	2.6	3.3	1.2	1.6	4.3
Outpatient psychiatric facility, incl. private psychiatrist, day care center	2.6	4.3	2.0	5.6	2.0	2.9	2.4	2.0	2.4	1.3
Private physician	1.0	8.5	1.2	.8	2.4	1.1	.6	.6	-	.4
Other health agency or medical facility	.7	4.3	3.3	.4	1.5	.6	.5	.4	4.8	.4
Social service agency	1.9	2.4	2.2	1.4	1.6	1.9	2.2	1.8	1.6	2.6
Court, correctional institution	1.8	1.2	2.0	.6	1.2	.8	3.4	1.5	1.6	3.0
School	2.4	3.0	14.5	.8	1.6	1.5	2.2	2.3	2.4	2.6
Other (incl. psychol. services, clergy, etc.)	.9	.9	1.6	1.2	.8	.7	1.3	.7	.8	1.7
Not stated	3.8	3.0	3.4	3.9	2.8	4.9	3.8	3.5	2.4	3.0

Source: Adolescent Patients Served in Outpatient Psychiatric Clinics (Tables 4a,b) by B. M. Rosen, R. Shellow and E. M. Bower. American Journal of Public Health 55: 1563-1577, October 1965.

Appendix Table 5

Disposition by Referral Source, Total and Treated Adolescent Patients Terminated from 780 Outpatient Psychiatric Clinics, United States, 1962

Disposition	Total	Referral source					
		Self, family, friend	School	Court	Social service agency	Private physician	Other
Total number of patients	52,970	10,337	13,116	6,337	6,892	8,933	6,851
Percentage distribution:							
Patient or family withdrew	31.4	38.9	31.6	20.5	19.7	37.4	32.1
Clinic terminated without referral:							
Further care not indicated	22.1	28.3	22.7	14.3	19.1	23.1	21.2
Other	8.2	9.0	7.9	8.0	6.7	7.7	10.1
Clinic terminated with referral to:	31.5	18.8	29.0	50.7	45.8	24.9	32.9
Inpatient psychiatric facility	5.7	4.5	3.7	7.6	6.3	5.7	8.8
Outpatient psychiatric facility, incl. private psychiatrist, day care center	3.4	4.0	2.8	2.0	1.7	4.3	5.7
Private physician	1.6	1.1	1.0	.3	.5	5.4	1.1
Other health agency or medical facility	1.5	.6	.7	.4	2.5	2.3	3.3
Social service agency	6.4	2.4	2.6	4.1	29.8	2.4	3.7
Court, correctional institution	5.6	1.2	2.4	33.9	1.8	.9	2.6
School	5.7	3.4	14.5	1.4	1.6	2.6	4.5
Other (incl. psychological services, clergy, etc.	1.6	1.6	1.3	1.0	1.6	1.3	3.2
Not stated	6.7	5.0	8.9	6.6	8.5	6.8	3.6
Number of treated patients	17,205	3,986	3,870	1,367	1,616	3,530	2,501
Percentage distribution:							
Patient or family withdrew	40.2	40.3	38.5	39.0	36.9	42.1	39.7
Clinic terminated without referral:							
Further care not indicated	32.8	36.7	36.3	27.6	28.3	33.7	27.5
Other	8.8	8.3	9.2	9.5	9.4	7.7	10.2
Clinic terminated with referral to:	14.7	11.2	13.3	21.9	18.5	12.2	19.9
Inpatient psychiatric facility	4.2	3.3	2.7	4.4	4.0	3.7	8.1
Outpatient psychiatric facility, incl. private psychiatrist, day care center	2.5	2.3	1.5	1.7	2.4	2.5	4.7
Private physician	1.0	1.0	.8	.2	.6	1.9	.8
Other health agency or medical facility	.5	.3	.5	.2	.7	.5	1.1
Social service agency	1.8	1.2	1.3	2.1	6.6	1.2	1.5
Court, correctional institution	1.7	.9	.9	10.9	1.9	.7	.7
School	2.1	1.4	4.9	1.5	1.1	1.0	1.5
Other (incl. psychological services, clergy, etc.)	.9	.8	.7	.9	1.2	.7	1.5
Not stated	3.6	3.6	2.6	2.0	6.9	4.4	2.8

Source: Adolescent Patients Served in Outpatient Psychiatric Clinics (Table 4c) by B. M. Rosen, R. Shellow and E. M. Bower. American Journal of Public Health 55: 1563-1577, October 1965.

Appendix Table 4

Percent Distribution of Disposition by Referral Source, of Total and Treated Patients under 18 Years of Age, Terminated from 801 Outpatient Psychiatric Clinics, United States, 1963

REFERRAL SOURCE 1/	Total No. of Patients	DISPOSITION: Not Referred: Patient Withdrew	Further Care Not Indicated	Other	Referred for Further Service to: Ment. Hosp. (Pub. & Priv.) Trt. Center for Children Other Inpatient Facility	Training School for the Mentally Retarded	Priv. Psy., Other Outpatient, Psy. Day Care Centers	Priv. Phys., Gen. Hospital, Other Medical	Social Service Agency, Priv. Psychologist	Court	School	All Other
All Children	73,894	27.7	22.9	10.3	4.6	2.2	4.0	5.1	7.7	4.6	7.7	3.0
Self, family, friend	14,650	34.4	30.6	11.0	3.2	1.6	4.7	2.6	4.2	1.1	4.2	2.4
Mental Hospital (Pub. & Priv.) Res. Trt. Ctr. for Children Other Inpatient Facility	1,940	31.3	18.4	8.6	12.3	4.4	5.2	2.8	5.0	7.3	3.9	2.8
Training School for the Mentally Retarded	182	6.6	8.2	2.2	3.3	69.2	1.7	2.2	1.1	.6	3.3	1.6
Private Psychiatrist, Other Outpatient, Day Care Center	2,168	31.5	24.6	10.0	9.8	2.1	9.9	2.9	3.9	1.1	2.2	2.2
Private Physician, General Hosp. Other Medical	19,395	26.5	25.4	11.0	4.2	2.7	4.4	13.5	4.0	.7	4.7	2.9
Social Service Agency, Private Psychologist	8,128	17.8	17.8	7.9	5.9	3.6	2.2	1.9	36.8	1.5	1.9	2.5
Court	6,737	17.5	12.7	6.4	7.1	1.3	2.5	.8	5.8	41.0	1.0	3.9
School	17,414	29.8	22.5	11.6	2.4	1.0	3.4	1.9	3.4	1.1	21.2	1.7
All Other	3,282	24.8	21.8	10.5	7.3	2.6	3.6	3.7	5.6	1.3	5.1	13.7
Treated Children 2/	25,415	32.9	38.2	10.7	3.5	.5	2.5	2.0	2.9	1.9	3.2	1.9
Self, family, friend	5,495	34.2	43.0	10.0	2.3	.6	2.3	.9	1.6	.6	2.6	1.7
Mental Hospital (Pub. & Priv.) Res. Trt. Ctr. for Children Other Inpatient Facility	798	32.5	26.0	5.6	14.2	.5	4.8	1.7	2.9	6.9	1.7	1.4
Private Psychiatrist, Other Outpatient, Day Care Center	939	33.1	36.1	10.6	5.5	.4	5.2	2.2	2.6	1.3	1.4	1.6
Private Physician, General Hosp. Other Medical	6,354	33.2	39.3	10.9	2.9	.7	2.5	4.2	2.0	.4	2.1	1.8
Social Service Agency, Private Psychologist	1,805	29.5	35.3	8.6	5.3	.7	2.2	1.4	12.4	1.5	1.4	1.9
Court	1,480	34.0	29.3	10.4	4.1	.4	1.5	.7	2.9	13.9	.9	1.9
School	5,496	32.6	38.0	12.6	2.7	.2	1.6	1.3	1.8	.9	6.7	1.6
All Other	1,080	29.7	36.2	10.8	3.5	.6	2.2	2.2	5.0	1.2	4.3	6.3

1/ Referral source groups of 25 patients or less omitted.

2/ Includes 12 treated patients referred by Training Schools for the Mentally Retarded.

Source: A Nationwide Survey of Outpatient and Other Psychiatric Services to Two Diagnostic Groups, Mentally Deficient Children and Psychotic Adults, 1963 (Table 3a) by B. M. Rosen, A. K. Bahn, B. S. Brown and P. H. Person. NIMH, 1966.

Appendix Table 5

Resident Patient Rates per 100,000 Population[1/], by Age and Sex, in State and County Mental Hospitals, United States, 1950-1965

Year	BOTH SEXES							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	341.2	3.0	84.6	234.2	453.7	624.7	763.9	1,057.3
1951	344.4	3.6	100.9	257.8	461.4	626.0	730.6	1,016.4
1952	346.9	3.7	97.4	251.1	452.2	634.6	738.6	1,058.4
1953	349.3	4.8	94.9	253.3	450.6	642.4	740.2	1,080.2
1954	348.2	4.6	94.9	252.2	443.9	639.9	731.5	1,105.9
1955	344.4	4.7	86.1	246.0	427.2	622.8	753.7	1,125.1
1956	333.5	5.2	82.3	230.1	402.9	602.0	752.2	1,109.6
1957	325.8	6.3	85.8	225.1	380.3	581.1	741.4	1,105.8
1958	318.0	6.7	85.3	218.2	361.6	566.4	731.1	1,099.2
1959	310.4	7.6	92.0	227.1	353.4	549.7	717.8	1,045.4
1960	300.6	7.9	91.9	216.4	333.5	538.1	711.3	964.8
1961	291.2	8.3	94.7	216.3	322.2	512.4	700.7	926.1
1962	280.6	8.4	92.8	211.8	309.3	490.0	683.3	885.8
1963	270.5	9.0	93.6	206.2	299.6	465.1	664.8	847.3
1964	259.0	8.6	94.5	201.3	289.4	439.4	636.1	805.3
1965	247.6	10.2	95.5	197.2	276.2	406.8	603.5	772.9

[1/] Rates are computed on the basis of July 1 civilian population, U.S. Bureau of Census, Current Population Reports, Series P-25.

Source: Patients in Mental Institutions, Part II, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 6

Male Resident Patient Rates per 100,000 Population[1/], by Age and Sex, in State and County Mental Hospitals, United States, 1950-1965

Year	MALE							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	338.1	3.5	102.8	249.5	476.8	620.0	701.9	1,033.0
1951	344.6	4.4	131.5	275.1	482.8	630.3	663.9	992.2
1952	346.3	4.4	127.1	269.7	470.3	644.3	668.9	1,031.3
1953	348.4	5.9	127.6	272.9	465.3	656.2	671.1	1,051.3
1954	345.3	5.6	124.2	271.4	453.6	659.0	665.9	1,069.1
1955	340.6	6.1	113.4	272.6	434.6	639.9	703.0	1,074.3
1956	330.0	6.9	110.0	257.6	411.3	622.4	707.7	1,055.9
1957	324.4	8.5	115.1	258.3	391.7	605.6	710.1	1,049.6
1958	317.2	9.1	113.9	254.8	374.2	592.8	712.6	1,038.5
1959	310.6	10.4	120.7	264.4	367.8	577.6	711.3	983.9
1960	302.1	11.0	123.5	254.6	344.4	562.0	718.1	903.1
1961	293.6	11.8	127.7	258.3	335.0	535.4	714.6	861.6
1962	284.1	11.8	125.0	260.1	323.1	512.3	705.0	819.4
1963	274.0	12.7	126.0	252.9	314.0	483.8	692.4	780.8
1964	262.8	12.0	126.7	250.2	306.5	455.4	666.1	738.9
1965	251.0	14.6	126.6	244.0	290.3	417.2	636.2	713.9

[1/] Rates are computed on the basis of July 1 civilian population, U.S. Bureau of Census, Current Population Reports, Series P-25.

Source: Patients in Mental Institutions, Part II, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 7

Female Resident Patient Rates per 100,000 Population[1/], by Age and Sex, in State and County Mental Hospitals, United States, 1950-1965

Year	FEMALE							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	344.2	2.5	67.6	220.0	431.4	629.4	825.8	1,079.0
1951	344.2	2.7	76.0	242.2	441.0	621.7	796.7	1,038.1
1952	347.4	2.9	74.1	234.4	435.0	625.1	807.1	1,082.3
1953	350.1	3.7	69.2	235.5	436.7	629.0	807.2	1,105.8
1954	351.0	3.5	71.1	234.7	434.7	621.1	794.5	1,138.0
1955	347.9	3.3	63.1	221.7	420.2	606.3	802.0	1,169.0
1956	336.8	3.4	58.3	204.9	395.1	582.2	794.3	1,155.5
1957	327.2	4.0	60.4	194.5	369.6	557.6	770.9	1,153.2
1958	318.8	4.2	59.6	184.5	349.9	541.0	748.2	1,149.8
1959	310.3	4.7	65.9	192.7	340.0	523.2	723.8	1,096.3
1960	299.2	4.7	63.4	181.3	323.3	515.1	705.0	1,015.8
1961	289.0	4.7	64.7	177.7	310.3	490.3	687.6	978.7
1962	277.4	4.8	63.7	167.9	296.6	468.7	663.0	939.5
1963	267.3	5.1	64.0	163.4	286.1	447.3	639.1	900.1
1964	255.5	5.1	64.9	156.6	273.5	424.2	608.3	857.4
1965	244.5	5.7	66.8	154.2	263.2	397.0	573.4	818.7

[1/] Rates are computed on the basis of July 1 civilian population, U.S. Bureau of Census Current Population Reports, Series P-25.

Source: Patients in Mental Institutions, Part II, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 8

First Admission Rates per 100,000 Population[1/], by Age and Sex, in State and County Mental Hospitals, United States, 1950-1965

Year	BOTH SEXES							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	75.9	2.8	58.8	83.8	99.2	97.4	101.9	234.0
1951	74.8	2.8	60.3	84.4	94.5	92.1	99.0	236.3
1952	77.1	3.0	61.7	90.1	98.2	95.7	99.7	241.4
1953	79.4	3.5	63.3	94.8	99.8	101.3	102.7	245.7
1954	76.3	3.5	62.2	95.8	103.6	101.1	93.5	217.7
1955	75.3	3.6	62.1	92.2	96.4	94.2	95.1	235.6
1956	75.9	4.2	63.8	91.0	96.0	96.9	99.6	236.1
1957	76.1	5.2	66.9	94.2	96.8	96.9	97.0	229.9
1958	80.1	5.6	72.1	100.6	101.7	103.2	103.2	237.7
1959	78.9	6.2	74.8	104.5	103.9	101.2	98.1	221.0
1960	78.6	6.5	79.3	108.2	104.5	101.6	96.9	198.2
1961	80.8	6.8	85.2	116.8	110.6	103.0	97.3	194.4
1962 [2/]	70.6	6.0	76.9	105.1	96.0	91.2	82.4	163.7
1963	70.8	5.9	79.5	107.0	99.3	90.4	82.3	155.9
1964	73.4	6.2	86.4	113.3	104.6	93.5	85.2	150.3
1965	75.1	7.5	88.6	118.5	106.6	96.6	86.1	146.5

[1/] Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

[2/] In 1962 the category Admissions With No Prior Psychiatric Inpatient Experience replaced the classification First Admissions. The major difference is that under the old classification prior psychiatric treatment in a general hospital was not considered previous psychiatric admission, whereas under the present classification such cases are included as having prior admission to an inpatient psychiatric facility.

Source: Patients in Mental Institutions, Part II, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 9

Male First Admission Rates per 100,000 Population[1], by Age and Sex, in State and County Mental Hospitals, United States, 1950-1965

Year	MALE							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	85.1	3.4	71.7	90.2	112.2	111.2	117.6	265.5
1951	84.2	3.2	76.8	90.8	106.5	106.2	113.6	270.1
1952	86.9	3.7	79.5	99.0	111.5	110.2	116.0	270.4
1953	90.7	4.4	81.8	108.9	116.3	117.2	121.2	273.6
1954	87.7	4.3	79.9	107.7	121.5	120.0	109.7	249.6
1955	86.1	4.5	79.9	105.2	112.2	111.9	110.8	265.8
1956	86.7	5.3	83.2	103.7	112.0	114.9	115.6	264.9
1957	87.6	6.9	86.8	109.4	114.8	116.1	112.6	258.1
1958	93.0	7.4	94.9	116.8	121.9	126.4	120.5	268.8
1959	90.5	8.3	94.5	118.7	122.9	121.5	113.9	250.1
1960	90.8	8.9	101.2	121.7	122.7	123.4	115.0	225.7
1961	93.4	9.0	106.4	131.8	128.9	125.3	116.4	225.2
1962 [2]	81.4	7.9	94.4	119.1	111.6	111.0	99.5	188.8
1963	82.9	7.9	98.0	122.2	116.9	111.8	103.2	183.6
1964	86.3	8.1	108.8	132.1	123.8	114.2	105.9	174.9
1965	88.5	9.7	109.3	138.7	127.3	119.3	107.7	171.7

[1] Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

[2] In 1962 the category Admissions With No Prior Psychiatric Inpatient Experience replaced the classification First Admissions. The major difference is that under the old classification prior psychiatric treatment in a general hospital was not considered previous psychiatric admission, whereas under the present classification such cases are included as having prior admission to an inpatient psychiatric facility.

Source: Patients in Mental Institutions, Part II, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 10

Female First Admission Rates per 100,000 Population[1], by Age and Sex, in State and County Mental Hospitals, United States, 1950-1965

Year	FEMALE							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	67.0	2.3	46.8	78.0	86.6	83.8	86.2	205.7
1951	65.9	2.4	46.9	78.7	83.0	78.3	84.6	206.3
1952	67.8	2.3	47.7	82.1	85.5	81.4	83.7	215.7
1953	68.7	2.5	48.8	82.0	84.2	85.8	84.7	221.3
1954	65.5	2.6	47.8	85.1	86.7	82.6	78.0	189.7
1955	65.1	2.6	47.6	80.3	81.5	77.1	80.1	209.4
1956	65.7	3.0	47.0	79.5	81.8	79.6	84.4	211.4
1957	65.2	3.5	49.7	80.3	80.1	78.5	82.4	206.0
1958	67.7	3.8	51.8	85.7	82.9	81.0	86.9	211.6
1959	67.9	4.0	56.8	91.4	86.2	81.8	83.5	197.0
1960	66.9	4.1	59.4	95.7	87.5	80.6	80.0	175.5
1961	68.9	4.6	65.9	102.9	93.6	81.6	79.4	169.2
1962 [2]	60.4	3.9	61.2	92.3	81.5	72.2	66.5	143.5
1963	59.3	3.8	62.6	93.0	83.0	70.0	62.9	133.9
1964	61.2	4.1	65.9	96.1	86.8	73.8	65.9	130.9
1965	62.4	5.2	69.4	100.0	87.4	75.2	66.2	127.0

[1] Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

[2] In 1962 the category Admissions With No Prior Psychiatric Inpatient Experience replaced the classification First Admissions. The major difference is that under the old classification prior psychiatric treatment in a general hospital was not considered previous psychiatric admission, whereas under the present classification such cases are included as having prior admission to an inpatient psychiatric facility.

Source: Patients in Mental Institutions, Part II, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 11

First Admission Rates per 100,000 Population[1], by Age and Sex,
in Private Mental Hospitals, United States, 1950-1965

Year	Both Sexes							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	27.5	0.4	16.4	34.2	45.4	48.1	37.4	52.7
1951	26.9	0.4	17.4	33.9	44.5	45.0	37.4	50.5
1952	26.7	0.6	19.5	34.4	42.3	43.6	35.0	47.0
1953	26.5	0.5	18.9	36.0	44.1	43.9	36.0	47.0
1954	24.4	0.6	16.7	39.0	40.3	40.7	33.9	42.4
1955	28.6	0.6	18.8	37.5	46.0	50.1	44.8	51.3
1956	26.4	0.7	17.5	34.6	41.5	46.8	44.1	47.2
1957	23.5	0.6	17.7	32.8	37.4	40.0	37.2	40.5
1958	26.1	0.7	20.5	37.6	41.2	43.0	41.7	45.4
1959	24.3	0.7	19.3	35.3	39.8	39.7	38.3	41.6
1960	24.6	1.0	20.3	38.3	40.5	42.0	37.0	36.6
1961	21.3	1.0	19.0	33.0	36.3	36.6	30.3	29.5
1962	22.6	1.1	21.4	36.1	38.9	36.7	31.2	31.3
1963	22.8	0.9	22.7	39.2	39.5	36.7	29.4	30.2
1964	21.7	1.2	22.4	37.2	37.7	34.2	28.9	26.7
1965	21.0	1.3	22.4	36.0	37.1	33.0	26.3	25.2

[1] Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

Source: Patients in Mental Institutions, Part III, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 12

Male First Admission Rates per 100,000 Population[1], by Age and Sex,
in Private Mental Hospitals, United States, 1950-1965

Year	Male							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	22.9	0.4	13.1	25.6	40.0	42.3	31.8	45.7
1951	22.7	0.4	15.4	25.3	38.4	40.1	32.8	45.1
1952	22.1	0.6	16.5	24.3	36.2	39.5	31.3	44.2
1953	22.0	0.5	15.5	26.0	37.8	38.9	30.9	42.2
1954	19.7	0.6	13.6	23.8	34.2	35.5	28.3	36.0
1955	22.7	0.6	15.5	25.2	36.9	43.6	36.7	44.6
1956	21.2	0.6	14.5	23.4	33.8	41.7	37.4	39.2
1957	18.8	0.7	15.3	22.3	29.3	36.5	31.8	33.3
1958	20.4	0.7	17.0	26.1	32.1	36.7	34.4	37.2
1959	19.1	0.6	16.1	24.5	30.5	34.5	32.9	34.1
1960	19.7	1.0	18.0	25.7	32.3	35.3	32.4	31.3
1961	16.7	1.2	16.5	21.3	26.9	30.8	27.8	25.1
1962	17.4	1.2	17.6	23.7	28.5	30.2	27.6	26.3
1963	17.3	1.0	18.5	25.3	28.6	29.9	25.4	25.4
1964	17.2	1.4	19.4	25.1	28.7	28.2	26.0	23.0
1965	17.0	1.4	19.6	24.6	27.5	29.1	24.5	22.7

[1] Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

Source: Patients in Mental Institutions, Part III, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 13

Female First Admission Rates per 100,000 Population[1], by Age and Sex,
in Private Mental Hospitals, United States, 1950-1965

Year	Female							
	Total	Under 15	15-24	25-34	35-44	45-54	55-64	65+
1950	31.9	0.4	19.5	42.2	50.6	53.9	43.0	59.0
1951	30.8	0.4	19.1	41.6	50.4	49.9	41.9	55.3
1952	30.0	0.6	21.9	43.5	48.0	47.7	38.6	49.5
1953	30.8	0.5	21.5	45.1	50.1	48.7	41.0	51.2
1954	28.8	0.7	19.2	43.3	46.1	45.7	39.2	48.0
1955	34.1	0.7	21.5	48.7	54.6	56.4	52.5	57.0
1956	31.4	0.7	20.1	44.8	48.7	51.7	50.4	54.1
1957	28.0	0.6	19.8	42.5	45.0	43.4	42.3	46.6
1958	31.5	0.8	23.7	48.2	49.6	48.9	48.6	52.2
1959	29.2	0.7	22.3	45.2	48.4	44.6	43.4	47.8
1960	29.4	1.0	22.5	49.9	48.0	48.4	41.2	41.0
1961	25.6	0.8	21.2	43.8	45.0	42.1	32.6	33.0
1962	27.5	1.0	24.7	47.4	48.6	43.0	34.6	35.4
1963	28.1	0.8	26.6	51.8	49.6	43.1	33.1	34.1
1964	26.0	1.0	25.2	48.2	46.0	40.0	31.5	29.6
1965	24.8	1.2	25.0	46.6	46.0	36.6	28.0	27.1

[1] Rates are computed on the basis of July 1 civilian population, U. S. Bureau of Census, Current Population Reports, Series P-25.

Source: Patients in Mental Institutions, Part III, 1950-1965. U. S. Department of Health, Education, and Welfare, PHS, NIMH.

Appendix Table 14

PERCENT OF SCHIZOPHRENICS UNDER 15 AND 15-24 YEARS RETAINED IN STATE AND COUNTY MENTAL HOSPITALS BY COLOR AND SEX, MRA COHORT STUDY, 1960

	Under 15 Years of Age					15-24 Years of Age				
		Percent Retained					Percent Retained			
Color and Sex	Total Number	Under 3 Months	6 Months	9 Months	12 Months	Total Number	Under 3 Months	6 Months	9 Months	12 Months
All Races	523	82.4	60.2	48.4	40.7	3,175	67.8	35.8	23.5	17.8
Male	361	84.2	63.7	50.1	42.4	1,818	71.5	38.2	25.5	19.4
Female	162	78.4	52.5	44.4	37.0	1,357	62.8	32.7	20.9	15.7
White	356	78.9	59.8	49.4	43.3	2,417	66.7	35.6	23.5	18.0
Male	242	81.0	63.6	52.1	46.7	1,372	70.4	37.2	25.1	19.2
Female	114	74.6	51.8	43.9	36.0	1,045	61.8	33.4	21.5	16.4
Nonwhite	167	89.8	61.1	46.1	35.3	758	71.1	36.5	23.5	17.3
Male	119	90.8	63.9	46.2	33.6	446	74.7	41.0	26.9	20.0
Female	48	87.5	54.2	45.8	39.6	312	66.0	30.1	18.6	13.5

Source: For Model Reporting Area Cohort Study
Arkansas, California, Illinois, Kentucky, Louisiana, Michigan,
Minnesota, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Wisconsin

Appendix Table 15

ESTIMATES AND PROJECTIONS OF THE TOTAL POPULATION OF THE UNITED STATES, BY AGE AND SEX: 1960 TO 1990

(In thousands. Figures relate to July 1 and include Armed Forces abroad. For an explanation of the assumptions underlying the four series of projections, see text. Figures inside heavy lines represent, in whole or part, survivors of births projected for years after 1966)

Series, age, and sex	1960[1]	1966[2]	1970	1975	1980	1985	1990
BOTH SEXES							
Series A							
All ages	180,684	196,842	208,615	227,929	250,489	274,748	300,131
Under 5 years	20,364	19,851	21,317	27,210	31,040	33,288	35,015
5 to 9 years	18,825	20,806	20,591	21,468	27,341	31,160	33,403
10 to 14 years	16,910	19,402	20,668	20,741	21,616	27,478	31,290
15 to 19 years	13,467	17,895	19,100	20,807	20,879	21,753	27,596
20 to 24 years	11,116	14,047	17,261	19,299	20,997	21,068	21,939
14 years and over	127,335	140,466	150,075	162,836	174,234	187,963	206,427
18 years and over	116,123	126,167	134,267	145,940	158,229	168,956	183,346
21 years and over	108,836	116,100	123,413	133,657	145,388	157,096	167,916
Series B							
All ages	180,684	196,842	207,326	223,785	243,291	264,607	286,501
Under 5 years	20,364	19,851	20,027	24,350	27,972	30,325	31,493
5 to 9 years	18,825	20,806	20,591	20,184	24,492	28,103	30,451
10 to 14 years	16,910	19,402	20,668	20,741	20,334	24,635	28,239
15 to 19 years	13,467	17,895	19,100	20,807	20,879	20,475	24,762
20 to 24 years	11,116	14,047	17,261	19,299	20,997	21,068	20,668
14 years and over	127,335	140,466	150,075	162,836	174,234	186,166	201,710
18 years and over	116,123	126,167	134,267	145,940	158,229	168,759	181,010
21 years and over	108,836	116,100	123,413	133,657	145,388	157,096	167,084
Series C							
All ages	180,684	196,842	206,039	219,366	235,212	252,871	270,770
Under 5 years	20,364	19,851	18,740	21,211	24,298	26,645	27,462
5 to 9 years	18,825	20,806	20,591	18,903	21,366	24,443	26,784
10 to 14 years	16,910	19,402	20,668	20,741	19,056	21,514	24,586
15 to 19 years	13,467	17,895	19,100	20,807	20,879	19,200	21,651
20 to 24 years	11,116	14,047	17,261	19,299	20,997	21,068	19,400
14 years and over	127,335	140,466	150,075	162,836	174,234	184,351	196,619
18 years and over	116,123	126,167	134,267	145,940	158,229	168,576	178,616
21 years and over	108,836	116,100	123,413	133,657	145,388	157,096	166,267
Series D							
All ages	180,684	196,842	204,923	215,367	227,665	241,731	255,967
Under 5 years	20,364	19,851	17,625	18,323	20,736	23,030	23,765
5 to 9 years	18,825	20,806	20,591	17,793	18,489	20,894	23,182
10 to 14 years	16,910	19,402	20,668	20,741	17,948	18,643	21,044
15 to 19 years	13,467	17,895	19,100	20,807	20,879	18,095	18,788
20 to 24 years	11,116	14,047	17,261	19,299	20,997	21,068	18,300
14 years and over	127,335	140,466	150,075	162,836	174,234	182,768	191,977
18 years and over	116,123	126,167	134,267	145,940	158,229	168,424	176,509
21 years and over	108,836	116,100	123,413	133,657	145,388	157,096	165,566
All Series—25 Years Old and Over							
25 to 29 years	10,933	11,611	13,878	17,449	19,475	21,163	21,234
30 to 34 years	11,978	10,956	11,437	13,974	17,522	19,536	21,215
35 to 39 years	12,542	11,789	11,061	11,464	13,980	17,501	19,502
40 to 44 years	11,681	12,436	11,900	10,995	11,396	13,883	17,362
45 to 49 years	10,926	11,636	12,223	11,692	10,812	11,212	13,653
50 to 54 years	9,655	10,695	11,103	11,840	11,335	10,493	10,889
55 to 59 years	8,465	9,330	10,040	10,552	11,262	10,794	10,006
60 to 64 years	7,162	7,931	8,451	9,279	9,770	10,442	10,022
65 to 69 years	6,264	6,378	6,883	7,470	8,223	8,681	9,299
70 to 74 years	4,769	5,190	5,214	5,721	6,234	6,889	7,302
75 years and over	5,625	6,889	7,488	7,968	8,606	9,407	10,404

See footnotes at end of table.

Appendix Table 15 (continued)

ESTIMATES AND PROJECTIONS OF THE TOTAL POPULATION OF THE UNITED STATES, BY AGE AND SEX: 1960 TO 1990--Continued

(In thousands. Figures relate to July 1 and include Armed Forces abroad. For an explanation of the assumptions underlying the four series of projections, see text. Figures inside heavy lines represent, in whole or part, survivors of births projected for years after 1966)

Series, age, and sex	1960[1]	1966[2]	1970	1975	1980	1985	1990
MALE							
Series A							
All ages	89,332	96,900	102,541	111,994	123,185	135,305	148,056
Under 5 years	10,352	10,135	10,887	13,898	15,857	17,008	17,893
5 to 9 years	9,572	10,580	10,507	10,958	13,958	15,910	17,059
10 to 14 years	8,595	9,861	10,500	10,580	11,030	14,024	15,972
15 to 19 years	6,815	9,088	9,694	10,555	10,634	11,084	14,065
20 to 24 years	5,560	7,064	8,711	9,741	10,596	10,674	11,122
14 years and over	62,208	68,198	72,699	78,764	84,249	90,986	100,195
18 years and over	56,529	60,930	64,672	70,179	76,089	81,294	88,423
21 years and over	52,853	55,829	59,167	63,953	69,567	75,260	80,570
Series B							
All ages	89,332	96,900	101,882	109,879	119,510	130,129	141,100
Under 5 years	10,352	10,135	10,228	12,437	14,290	15,494	16,094
5 to 9 years	9,572	10,580	10,507	10,303	12,504	14,350	15,551
10 to 14 years	8,595	9,861	10,500	10,580	10,376	12,573	14,415
15 to 19 years	6,815	9,088	9,694	10,555	10,634	10,433	12,620
20 to 24 years	5,560	7,064	8,711	9,741	10,596	10,674	10,475
14 years and over	62,208	68,198	72,699	78,764	84,249	90,070	97,792
18 years and over	56,529	60,930	64,672	70,179	76,089	81,193	87,234
21 years and over	52,853	55,829	59,167	63,953	69,567	75,260	80,147
Series C							
All ages	89,332	96,900	101,225	107,622	115,386	124,137	133,073
Under 5 years	10,352	10,135	9,571	10,835	12,413	13,614	14,034
5 to 9 years	9,572	10,580	10,507	9,649	10,908	12,481	13,679
10 to 14 years	8,595	9,861	10,500	10,580	9,724	10,980	12,550
15 to 19 years	6,815	9,088	9,694	10,555	10,634	9,783	11,034
20 to 24 years	5,560	7,064	8,711	9,741	10,596	10,674	9,830
14 years and over	62,208	68,198	72,699	78,764	84,249	89,144	95,198
18 years and over	56,529	60,930	64,672	70,179	76,089	81,100	86,015
21 years and over	52,853	55,829	59,167	63,953	69,567	75,260	79,731
Series D							
All ages	89,332	96,900	100,656	105,581	111,533	118,450	125,518
Under 5 years	10,352	10,135	9,002	9,360	10,594	11,768	12,146
5 to 9 years	9,572	10,580	10,507	9,083	9,440	10,669	11,840
10 to 14 years	8,595	9,861	10,500	10,580	9,159	9,515	10,742
15 to 19 years	6,815	9,088	9,694	10,555	10,634	9,220	9,575
20 to 24 years	5,560	7,064	8,711	9,741	10,596	10,674	9,271
14 years and over	62,208	68,198	72,699	78,764	84,249	88,337	92,833
18 years and over	56,529	60,930	64,672	70,179	76,089	81,022	84,943
21 years and over	52,853	55,829	59,167	63,953	69,567	15,260	79,375
All Series--25 Years Old and Over							
25 to 29 years	5,423	5,770	6,935	8,758	9,779	10,626	10,705
30 to 34 years	5,901	5,429	5,674	6,971	8,778	9,792	10,633
35 to 39 years	6,140	5,801	5,464	5,674	6,959	8,748	9,753
40 to 44 years	5,733	6.064	5,825	5,408	5,617	6,882	8,645
45 to 49 years	5,384	5,658	5,919	5,684	5,282	5,489	6,725
50 to 54 years	4,758	5,197	5,344	5,663	5,444	5,065	5,269
55 to 59 years	4,143	4,491	4,789	4,974	5,278	5,081	4,735
60 to 64 years	3,418	3,757	3,957	4,293	4,467	4,747	4,577
65 to 69 years	2,929	2,901	3,123	3,341	3,635	3,794	4,043
70 to 74 years	2,195	2,261	2,230	2,439	2,624	2,869	3,011
75 years and over	2,413	2,841	2,983	3,056	3,248	3,512	3,850

See footnotes at end of table.

Appendix Table 15 (continued)

ESTIMATES AND PROJECTIONS OF THE TOTAL POPULATION OF THE UNITED STATES, BY AGE AND SEX: 1960 TO 1990--Continued

(In thousands. Figures relate to July 1 and include Armed Forces abroad. For an explanation of the assumptions underlying the four series of projections, see text. Figures inside heavy lines represent, in whole or part, survivors of births projected for years after 1966)

Series, age, and sex	1960[1]	1966[2]	1970	1975	1980	1985	1990
FEMALE							
Series A							
All ages	91,352	99,942	106,075	115,935	127,304	139,443	152,075
Under 5 years	10,013	9,715	10,430	13,312	15,183	16,280	17,122
5 to 9 years	9,254	10,226	10,085	10,510	13,383	15,249	16,344
10 to 14 years	8,314	9,542	10,169	10,161	10,586	13,454	15,318
15 to 19 years	6,652	8,807	9,407	10,252	10,245	10,669	13,532
20 to 24 years	5,556	6,983	8,551	9,558	10,401	10,394	10,817
14 years and over	65,127	72,268	77,376	84,072	89,985	96,977	106,231
18 years and over	59,594	65,237	69,595	75,761	82,139	87,663	94,923
21 years and over	55,983	60,271	64,246	69,703	75,821	81,836	87,346
Series B							
All ages	91,352	99,942	105,444	113,907	123,781	134,479	145,400
Under 5 years	10,013	9,715	9,799	11,912	13,682	14,831	15,399
5 to 9 years	9,254	10,226	10,085	9,881	11,988	13,753	14,899
10 to 14 years	8,314	9,542	10,169	10,161	9,958	12,062	13,824
15 to 19 years	6,652	8,807	9,407	10,252	10,245	10,042	12,142
20 to 24 years	5,556	6,983	8,551	9,558	10,401	10,394	10,193
14 years and over	65,127	72,268	77,376	84,072	89,985	96,096	103,918
18 years and over	59,594	65,237	69,595	75,761	82,139	87,566	93,776
21 years and over	55,983	60,271	64,246	69,703	75,821	81,836	86,937
Series C							
All ages	91,352	99,942	104,814	111,743	119,826	128,734	137,697
Under 5 years	10,013	9,715	9,169	10,376	11,885	13,031	13,428
5 to 9 years	9,254	10,226	10,085	9,254	10,458	11,962	13,105
10 to 14 years	8,314	9,542	10,169	10,161	9,332	10,534	12,035
15 to 19 years	6,652	8,807	9,407	10,252	10,245	9,417	10,617
20 to 24 years	5,556	6,983	8,551	9,558	10,401	10,394	9,570
14 years and over	65,127	72,268	77,376	84,072	89,985	95,207	101,421
18 years and over	59,594	65,237	69,595	75,761	82,139	87,476	92,601
21 years and over	55,983	60,271	64,246	69,703	75,821	81,836	86,535
Series D							
All ages	91,352	99,942	104,268	109,787	116,133	123,280	130,449
Under 5 years	10,013	9,715	8,623	8,963	10,142	11,262	11,620
5 to 9 years	9,254	10,226	10,085	8,710	9,049	10,225	11,342
10 to 14 years	8,314	9,542	10,169	10,161	8,789	9,128	10,301
15 to 19 years	6,652	8,807	9,407	10,252	10,245	8,876	9,214
20 to 24 years	5,556	6,983	8,551	9,558	10,401	10,394	9,030
14 years and over	65,127	72,268	77,376	84,072	89,985	94,431	99,145
18 years and over	59,594	65,237	69,595	75,761	82,139	87,402	91,566
21 years and over	55,983	60,271	64,246	69,703	75,821	81,836	86,191
All Series--25 Years Old and Over							
25 to 29 years	5,510	5,841	6,943	8,692	9,696	10,537	10,530
30 to 34 years	6,077	5,527	5,763	7,003	8,744	9,745	10,582
35 to 39 years	6,402	5,988	5,597	5,789	7,022	8,753	9,748
40 to 44 years	5,948	6,372	6,075	5,587	5,779	7,001	8,717
45 to 49 years	5,541	5,978	6,304	6,008	5,531	5,723	6,928
50 to 54 years	4,896	5,498	5,759	6,177	5,891	5,428	5,620
55 to 59 years	4,322	4,839	5,250	5,578	5,984	5,713	5,271
60 to 64 years	3,744	4,174	4,494	4,986	5,303	5,695	5,444
65 to 69 years	3,335	3,476	3,760	4,129	4,588	4,887	5,256
70 to 74 years	2,574	2,929	2,984	3,281	3,611	4,020	4,292
75 years and over	3,212	4,047	4,505	4,913	5,358	5,896	6,554

[1] Estimates previously published in Current Population Reports, Series P-25, No. 321.

[2] Estimates previously published in Current Population Reports, Series P-25, No. 352.

Source: Projections of the Population of the United States, by Age, Sex and Color to 1990, with Extensions of Total Population to 2015 (Table 4). Current Population Reports, Population Estimates, Series P-25, No. 359, February 20, 1967. U.S. Department of Commerce, Bureau of the Census.

Appendix 16

Assumptions and Methodology for Obtaining Projections of Manpower Needs and Demands for Service

Based on Projections of Outpatient Psychiatric Clinic and Public Mental Hospital Data

Assumptions:

1. **Rate of increase in the number of children served in clinics and hospitals will continue as it has in the past.**

2. **The same proportion of core professionals will work in psychiatric facilities in 1972 as in 1965.**

3. **The amount of time spent to provide service to children is the same as that given to an adult.**

Assumption 1. Rate of increase in the number of children under 18 years of age served in outpatient clinics and hospitals will continue as it has in the past.

Outpatient Psychiatric Clinics

a. Average annual rate of change, children served in clinics.	
1959-1966 7.9% per year	
b. Expected number of children in general population in 1972 (Population Projections, B Series)	**74,973,000**
c. Expected rate per 100,000 population under 18 years, 1972	**892.5**
d. Expected number of children to be served in clinics in 1972	**669,000**
e. Expected number of children to be served in clinics in 1975	**873,000**

(1975 rate = 1,121.2)
(1975 expected population under 18 years, B series = 77,845,000)

Public Mental Hospitals

a. Average annual rate of change, children resident in public mental hospitals in 1953-1963[1]	**16%**
b. Expected number of children to be served in public mental hospitals in 1972	**66,000**
c. Expected number of children to be served in public mental hospitals in 1975	**103,000**
Public mental hospital and other hospital population in 1975	**247,000**
Total persons to be served in 1975 (hospitals and clinics)	**1,120,000**

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[1] **Source: Some Implications of Trends in the Usage of Psychiatric Facilities for Community Mental Health Programs and Related Research by M. Kramer. PHS Publication 1434, U.S. Government Printing Office, Washington, D. C., 1966.**

Assumption 2. **Same proportion of core professionals will work in psychiatric facilities in 1972 as in 1965.**

a. **Mental Health Professional Staff - 1965**

Type of Staff	Outpatient Psychiatric Clinics (Full-time equivalent)	Public Mental Hospitals (Full-time)
Psychiatrists	3,813	3,224
Psychologists	2,731	1,813
Social Workers	4,622	3,653
Nurses	328	18,022

b. **Mental Health Professional Staff**

	Employed in 1965			Projections for 1972	
Type of Staff	Number in Clinics and Hospitals (1)	Total Number in U.S. 1/ (2)	Percent in Clinics and Hospitals (3)=(1)/(2)	Total Number in U.S. 2/ (4)	Number in Clinics and Hospitals (5)=(3).(4)
Psychiatrists	7,037	18,750	37.5	26,169	9,813
Psychologists	4,544	13,265	34.3	23,536	8,073
Social Workers	8,275	11,378	72.7	20,561	14,948
Nurses	18,350	20,554	89.3	29,187	26,064
Total[3/]	38,206				58,898

1/ Source: Mental Health Training and Manpower, 1968-1972 (Table 1). Division of Manpower and Training Programs, NIMH, April 1967.

2/ Source: Mental Health Training and Manpower, 1968-1972 (Table 8). Division of Manpower and Training Programs, NIMH, April 1967.

3/ Total mental health "core" professionals in clinics and public mental hospitals, (full-time equivalent).

Appendix 16 (continued)

Assumption 3. The amount of time spent to provide service to children is the same as that given to an adult.

a.

	Number of Professionals in 1965	Percent of Children in Facilities	Number of Professionals Serving Children in 1965
Mental Health Core Manpower:			
In clinics	11,494	35%	4,023
In public mental hospitals	26,712	3.4%	908
Total	38,206		4,931

b. Percent of time for children in 1965 4,931/38,206 = 13%

c. Number of mental health professionals in 1972 = 7,657 (58,898 . 13%)

d. Ratio; Number of Children Served / Manpower, 1965

$$\frac{384{,}000 \text{ (in clinics in 1965)} + 27{,}000 \text{ (in mental hospitals in 1965)}}{4{,}931}$$

$$= \frac{411{,}000}{4{,}931} = 83.4$$

1 Mental Health Core Professional for 83 children in 1965

THEREFORE:

If (1) 735,000 children are expected to seek service in 1972 (Assumption 1) and (2) 1 professional for 83 children is needed to maintain current quality of service (Assumption 3)

(3) then 8,855 professionals are needed in 1972 just to maintain status quo (statements (1) and (2).

(4) We can expect to have 7,657 professionals (Assumptions 2b and 3c) in 1972. Hence, we will be 14% short of current levels of service.

[Reprint from magazine "Social Work" January 1972]

"Group Care for Children: Guidelines for Planning" by James K. Whittaker. pp. 51–61, "Social Work" magazine, January 1972

GROUP CARE FOR CHILDREN: GUIDELINES FOR PLANNING

by James J. Whittaker

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Growing interest in group care for children highlights the fact that present theory consists of a patchwork of theoretical remnants, practice models, and traditional values. This article presents a historical analysis of the development of group care in the United States—and this society's ambivalent attitudes toward its children—from which are derived guidelines for planning and implications for further research.

Serious questions are being raised about the viability and effectiveness of traditional child welfare services. Both the criteria for defining present services and their efficacy in dealing with the problems they were designed to alleviate have come under scrutiny. Criticism and doubt are nowhere more evident than in the controversy surrounding the current provision of group care services for children. The century-old debate over institutional care versus foster home care is much in evidence, as is a growing concern about institutional facilities for delinquent children.[1]

Delinquency studies have shown that the mere transposition of traditional social work methods from the community agency to the children's institution—without proper attention to the factors of group living, the impact of the total milieu, and the effects of the peer culture—is an inadequate solution to the problem of the individual delinquent.[2] Also, studies by Wolins and others have indicated that many of the traditional prejudices against raising children in group care facilities may not be based on fact.[3] The community mental health movement, with its emphasis on prevention and remediation within the family unit, makes it imperative for those who feel that group care facilities still have a place and purpose in the overall structure of children's services to define just what that place and purpose should be.

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[1] For an excellent historical perspective on the institution-versus-foster home controversy, *see* Martin Wolins and Irving Piliavin, *Institution or Foster Family: A Century of Debate* (New York: Child Welfare League of America, 1964). *See also* Henry S. Maas and Richard E. Engler, *Children in Need of Parents* (New York: Columbia University Press, 1959): Joseph F. Meisels and Martin B. Loch, "Unanaswered Questions About Foster Care," *Social Service Review*, Vol. 30, No. 1 (March 1956), pp. 239–216; Leon Eisenberg, "The Sins of the Fathers: Urban Decay and Social Pathology," *American Journal of Orthopsychiatry*, Vol. 32, No. 1 (January 1962), pp. 5–17; and Wolins, *Selecting Foster Parents* (New York: Columbia University Press, 1963).

[2] *See* Howard W. Polsky, *Cottage Six* (New York: Russell Sage Foundation, 1962); and Polsky, et al., *The Dynamics of Residential Treatment: A Social System Analysis* (Chapel Hill: University of North Carolina Press, 1968).

[3] *See* Martin Wolins, "Child Care in Cross Cultural Perspective,'' unpublished monograph, University of California at Berkeley, 1969; Wolins, "Group Care: Friend or Foe?'' *Social Work*, Vol. 4, No. 1 (January 1969), pp. 35–54; Wolins, "Group Care and Intellectual Development," unpublished monograph, University of California at Berkeley, 1969; and Wolins, "Young Children in Institutions: Some Additional Evidence," paper presented at the 45th Annual Meeting of the American Orthopsychiatric Association, Chicago, Ill., March 20-23, 1968. *See also* A. I. Rabin, *Growing Up in the Kibbutz* (New York: Springer Publishing Co., 1965); Rabin, "Infants and Children Under Conditions of Intermittent Mothering in the Kibbutz," *American Journal of Orthopsychiatry*, Vol. 28 (1958), pp. 577–584; and Rabin, "*Kibbutz Adolescents*," *American Journal of Orthopsychiatry*, Vol. 31 (1961), pp. 493–504.

This paper discusses the implications for future research and planning that were derived from a historical analysis of the development of child care institutions in the United States.[4] The rationale for conducting such research was that child welfare planners—particularly in the group care field—could profit from an analysis of the origin of child care institutions and their modification by changing service needs and new philosophical and technological systems. The underlying assumption of the research was that there is no unified theory of group care from which to deduce and test hypotheses, but rather a patchwork of theoretical remnants, practice models, and traditional values borrowed from a variety of sources. Thus an exploratory study that sought to yield hypotheses and directions for future research seemed more appropriate than a classic experimental study.

The foregoing should serve as a warning to those who would view the guidelines discussed in this article as a blueprint for the future development of child care institutions. This would constitute a misuse of the data and a misperception of the purposes of the research. The guidelines and implications for research should be taken as reflections of the dominant trends in the development of child care institutions in the United States. Valadation of specific care models and organizationsl patterns must be left to future research.

The data were organized under five topical areas: (1) philosophies of child care, (2) child care institutions as part of the total child welfare field, (3) organization and technology for care and treatment, (4) group methods of child rearing, and (5) the child care institution and the national organization. Each section, with the exception of the first, contains guidelines for future development and implications for research.

PHILOSOPHIES OF CHILD CARE

Although there has been much discussion of the "rights of children," most children—especially those who require care away from their natural home—have little control over their immediate circumstances. Furthermore, "rights of children' implies responsibility on the part of the nation that proclaims its devotion to the young. "Yet we find ourselves dismayed by the violence, frustration and discontent among our youth and by the sheer number of emotionally, mentally, physically and socially handicapped children in our midst." [5] This country seems to have no unified national commitment to its children and youths.

Part of the discrepancy between formally stated goals, values, and policies and actual practices in the child care field comes from a failure to understand and appreciate the role of the child in this society. There is an assumed unity of purpose to provide care, treatment, and rehabilitation for children in need—particularly those who are dependent-neglected, delinquent, or emotionally disturbed.

However, the history of institutional child care in America indicates that from colonial times to the present as many efforts to "help" have been motivated by a concern for idleness, lack of productivity, presumed moral depravity, and protection of society as with a genuine concern for aiding needy children. Furthermore, helping persons, who have genuinely attempted to deal with specific aspects of the child welfare problem, have often been insensitive to the cultural values and attitudes of their intended beneficiaries. For example, the attempts of Charles Loring Brace and the New York Children's Aid Society—as well as numerous other Protestant children's societies in the nineteenth century—to deal with the problems of dependency and delinquency by sending vagrant city children to live with farmers in the West (called "placing out") met with considerable opposition from the Roman Catholic Irish, German, and Italian immigrants, who viewed the movement as nothing more than a nativist plot to neutralize the concentrations of "dangerous classes" in the eastern cities.

What Chambers labeled the "crusade for children"—the battle against the exploitation of children in mines, streets, factories, and fields—has realized its major gains only in recent decades.[6] When those children who need care outside their own homes are considered, the extent of the remaining problem becomes evident. For example, the 1930 White House Conference on Children and Youth stated:

> The emotionally disturbed child has a right to grow up in a world which does not set him apart, which looks at him not with scorn or pity or ridicule—but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.[7]

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[4] For the complete study *see* James K. Whittaker, "Planning for Child Care Institutions." Unpublished doctoral dissertation, University of Minnesota, 1970.

[5] *Digest of Crisis in Child Mental Health: Challenge for the 1970's* (Washington, D.C.: Joint Commission on the Mental Health of Children, 1969), p. 1.

[6] Clarke A. Chambers, *Seedtime of Reform* (Minneapolis: University of Minnesota Press, 1963), p. 27.

[7] As quoted in *Digest of Crisis in Child Mental Health*, p. 4.

Forty years later, the Joint Commission on the Mental Health of Children reported that the care of the emotionally disturbed child in the United States had "worsened considerably." Using what it called a "conservative estimate," the National Institute of Mental Health indicated that in 1966 some 1.4 million children under age 18 were in need of psychiatric care.[8] Of these, nearly a million did not receive treatment. Thus in this one area alone care is being provided for about one-third of those who need it.

Just as the technology of institutional child care needs further study, experimentation, and refinement, so also the philosophy of child care—as reflected in current conditions—needs a vigorous reexamination. The 1920s marked the gradual demise of social work's active concern with the progressive reforms of the earlier part of the century in favor of a heightened awareness of the impor- great developments in the ways in which we can care for, treat, and rehabilitate tance of "function" and "professionalization." The ensuing years have witnessed the delinquent, emotionally disturbed, or dependent-neglected child. Perhaps what the field of child welfare now needs most are reformers, in the tradition of Homer Folks, Lillian Wald, and Hastings Hart, who will raise a moral clamor and assert political pressure that will result in meaningful changes for children.

Continuum of Services

One clearly defined principle of the architects of child welfare policy for the period 1900–30, such as C. C. Carstens and Hastings H. Hart, was that child care institutions should be treated as an integral part of the total continuum of social services for children. The early separation of institutions from other services no doubt influenced their poor image in the community and fostered the picture of the barracks-style, congregate type of care and the regimentation of life that were so abhorrent to "child nature." Indeed all child care facilities suf- in which children were crammed and to which they were sent when they got into fered (as many still do) from the stereotype of the mysterious, isolated institution trouble with the law. As Wolins and Piliavin state:

> The institution is threatened by its tradition of isolation. It may tend to remain, as it has so often in the past, a collection of social outcasts, juvenile and adult, who for reasons of their own or others have been brought together to live under highly artificial conditions cuphemistically described as "family life." [9]

"Too often group care is related more to professional preference than to the actual needs of children."

If the child care institution is to fulfill a useful function in the child welfare field, it cannot remain isolated. Part of the problem has to do with the attitudes, values, prejudices, and biases of child welfare professionals. For example, the child welfare field must wholeheartedly accept a "both-and" logic, rather than the "either-or" philosphy that has prevailed in the past. Arguments about which is best—foster care or group care—must give way to a reasoned analysis of what kinds of group and foster care facilities are best for certain types of children. Moreover, this analysis must be based on evidence rather than on value judg- service. The following guidelines are presented to help facilitate the goal of inte- ments that make a priori assumptions about the relative worth of each type of grating child care institutions into the overall structure of childrens' services.

Guidelines. Children's services in the public sector, currently organized under the categories of mental health, corrections, and welfare, should be subsumed under new state departments of children's services. Organization at this level of government appears to be financially and administratively feasible and would help avoid duplication of facilities. Each state department of children's services would relate directly—in terms of funding, consultation, research, and help in policy formulation—to a unified federal children's agency—possibly the newly organized Office of Child Development.

The current system of services presupposes that the populations of children served can be designated by diagnostic categories and that each service's program best serves the needs of its specific population. Neither assumption seems warranted. Children in need tend to fall into a field of service more by chance than by choice. In many cases diagnosis is largely determined by which agency has the initial contact with the child. One hypothetical and fairly typical case is that of a latency-age child from a lower-class disorganzied "multi-problem" family, who has marked learning difficulties in school, is a frequent truant and petty thief, and gets into fights in the neighborhood. If such a child were seen first at a mental health center, he might well be labeled "emotionally disturbed" and sent to a residential treatment center. The same child could be categorized as "dependent-neglected" by the department of child welfare and recommended for a group foster home or he could be labeled "delinquent" by the juvenile court and sent to an institution for delinquents.

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[8] *Crisis in Child Mental Health: Report of the Joint Commission on the Mental Health of Chidren* (New York: Harper & Row, 1970), p. 5.

[9] Op. cit., p. 19.

The problem, of course, is that few children fit neatly into any category, but often have a combination of problems. Thus the overall structure of children's services must be able to provide, as Homer Folks said, "the right thing, for the right child, at the right time." This can be accomplished most easily when there is a chain of children's services—including all types of outpatient, foster care, and institutional options. Private children's facilities could fill needed service gaps (as they do now) and serve as a locus for research and demonstration without having to wrestle with their eligibility to receive state aid under existing categories.

Research implications. If one accepts the integration of all categorical public services for children, several research questions become evident:

1. What are the distinguishing factors of the populations of children to be served? What are their special needs and how may these needs best be related to services?

2. What will be the role of the private child care institution or agency? How will it function: as a research and demonstration project, ancillary service, or back-up facility?

3. How will the new system of children's services relate to the other systems that are part of the child's life? For example, how will the educational system mesh with the system of children's services?

4. How does one design a coordinated continuum of children's services? What sorts of linkages and coordinating mechanisms will be appropriate among the various elements of the system? What will be the form of administration? How will "success" or "failure" be determined—in terms of treatment or rehabilitation?

ORGANIZATION AND TECHNOLOGY

There would be a need for specifying an organization and technology for the various types of child care institutions within an overall structure of children's services. Historical analysis would appear to indicate the following directions in this area.

Guidelines. The basic form of organization in the child care institution should reflect children's, not professionals' needs. Several steps would be required to devise this organization:

1. Specifying in general and specific terms the problems of the population to be served.

2. Specifying what will constitute successful treatment or rehabilitation.

3. Determining the various means by which the treatment goals may be achieved.

4. Defining the role structure of the child care institution—"who-does-what"—in terms of what needs to be done, instead of having a preconceived notion about what the functions of the various professional-nonprofessional groups should be. In this regard a classification for assigning duty functions according to children's needs and staff skills, rather than professional needs, is sorely needed. Too often group care is related more to professional preference than to the actual needs of the children.[10]

The message of history clearly indicates that what is avant garde in treatment technology today will quickly become passe. Thus child care institutions—in fact all children's services—should be organized to permit the infusion of new modes of treatment and care as well as the evaluation of old ones. However, this seemingly simplistic goal becomes extremely difficult to implement. Institutions often become wedded exclusively to one technology. This implies that all children in an institution can be treated or cared for within the framework of a single technology—a logic that appears to disregard developmental and/or functional differences.

Research implications. From these recommendations, several research questions become apparent:

1. What forms of organizational structure provide maximum openness to new technologies?

2. How may the duty functions in a child care institution best be related to the needs of children, rather than professionals?

3. How may organizational goals be translated into measurable quantities that lend themselves to evaluative research? This question leads to several areas includ-

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[10] For one attempt to devise such a framework, *see* John C., Kidneigh, "Restructuring Practice for Better Manpower Use," *Social Work*, Vol. 13, No. 2 (April 1968), pp. 109–114. *See also* James Bridges, *Job Purification and Job Satisfaction in Social Welfare*. Unpublished doctoral dissertation, University of Minnesota, 1970.

ing budgeting, in which the unit-cost-of-service approach may be more advantageous than the more commonly used program budget.

4. How may current theories and models—e.g., social learning theory, psychoanalytic ego psychology, and small-group dynamics—be synthesized into a dynamic and unified theory of institutional child care? [11]

5. How can reliable measures for evaluating institutional care be developed? Many current studies of the effectiveness of institutional care are essentially ex post facto evaluations of progress executed without the benefit of controls so that the differences between changes occurring from treatment and from developmental factors are obfuscated.[12]

6. What relevance do cross-cultural developments have for the American child care institution—for example, Linton's study of European methods of training child care staff and Brown's experiments in Canada with the "therapeutic family." [13]

GROUP METHODS

Although the debate over foster home care versus institutional or group care has been slightly less acrimonious in recent years, it is far from resolved. On the one hand, some research is beginning to temper many child welfare workers' deep-seated prejudice against rearing children in settings other than the nuclear family.[14] On the other hand, the government seems to be shifting its policy—as articulated in the first White House Conference on Children and Youth (1909) and reaffirmed by every succeeding conference—that "the home is the highest and finest product of civilization and children should not be separated from their parents for reasons of poverty alone." [15] Implicit in the proposed Nixon welfare recommendations is the message that the home is the "highest and finest product of civilization" for *some* children and that children may be separated from their parents (at least for day care) only because they are poor. It seems crucial that two problems be distinguished: the effectiveness of communal child rearing as an alternative to the nuclear family and the separation of children from their families for day care solely because they are poor. Given the fact that group child rearing is emerging as a viable alternative to individual foster care, the following guidelines seem to be appropriate.

Guidelines. Child welfare theoreticians—particularly those concerned with the role of child care institutions in the continuum of children's services—should begin to think less in terms of the illness model and institutional treatment and more in terms of corrective socialization or education for life. In short the problem child from the disorganized family may need good child rearing and a stable environment in which to grow up more than treatment. This is especially true of the child from the milti-problem family, who before he reaches adolescence may have been shunted from one institution to another—child welfare shelter, individual foster home, correctional institution, and residential treatment center—interspersed with short stays in an inadequate family environment.

This is not to suggest wholesale group rearing for problem children whose parents cannot cope with them. Nor is it meant to downgrade treating children in the family. Rather, it is suggested that family treatment be expanded and group facilities be made available for those parents who are unable to care properly for their children. Currently there are few group care facilities in most states, despite the many parents who would probably agree to place their children in such settings rather than have them placed in individual foster homes. The problem, as Glaser states it, is that "we have to change our concept from any home is better than an institution to a good home is better than a good institution."[16]

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[11] For two attempts in this direction *see* Henry W. Maier, *Three Theories of Child Development* (New York: Harper & Row, 1969), and Albert E. Trieschman, James K. Whittaker, and Larry K. Brendtro, *The Other 23 Hours* (Chicago: Aldine Publishing Co., 1969).

[12] *See*, for example, Melvin E. Allerhand, R. E. Weber, and M. Haug, *Adaptation and Adaptability: The Bellefaire Follow-Up Study* (New York: Child Welfare League of America, 1966).

[13] *See* Thomas E. Linton, "The European Educateur Program for Disturbed Children," *Forum for Residential Therapy*, Vol. 2, No. 1 (Spring 1969), pp. 4–26; and *Involvement: A Quarterly Journal from Browndale*, esp. Vol. 11, No. 1 (Summer 1969).

[14] Much of this prejudice had its roots in the research conducted by Spitz, Bowlby, and others on the effects of maternal separation on the development of the young child. These early studies, many conducted under the auspices of the World Health Organization, have in more recent years been called into question by other researchers. *See*, for example, Rene A. Spitz, "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," *Pskchoanalytic Study of the Child*, Vol. 1 (New York: International Universities Press, 1945), pp. 53–75; John Bowlby, *Maternal Care and Mental Health* (Geneva, Switzerland: World Health Organization, 1952); Bowlby, "The Nature of the Child's Tie to His Mother," *International Journal of Pskcho-Analysis*, Vol. 39 (1958), pp. 350–373; and Sally Provence and Rose C. Lipton, *Infants in Institutions* (New York: International Universities Press, 1962). For additional sources on the effects of institutionalization, *see* Mary D. Ainsworth, et al., *Deprivation of Maternal Care: A Reassessment of Its Effects* (Geneva, Switzerland: World Health Organization, 1962), pp. 159–165; *Maternal Deprivation* (New York: Child Welfare League of America, 1962); Wolins and Piliavin, op. cit., pp. 48–62; Bowlby, *Attachment* (New York: Basic Books, 1969); and Spitz and Katherine Wolf, "Anaclitic Depression," *Pskchoanalytic Study of the Child*, Vol. 2 (New York: International Universities Press, 1946), pp. 313–342.

[15] *Proceedings of the Conference on the Care of Dependent Children* (Washington, D.C.: U.S. Government Printing Office, 1909).

Implications for research. Research in group child-rearing methods should be continued and greatly expanded in the following areas: maternal deprivation, multiple mothering, effects of institutional placements, and organizational requisites for group care facilities.

1. A far more precise definition than currently exists in the literature is needed for terms like "maternal deprivation," "institutionalization," and "social environment." In particular, an attempt should be made to explore the consequences of maternal separation *without* a concomitant physical, financial, or emotional crisis to determine the actual effects of separation itself.[17]
2. Basic research in child development should be continued to determine the kinds of stimulation necessary to assure adequate functioning in certain areas, e.g., language development.
3. The concept of the critical phase in child development should be fully explored, with specific reference to the time interval after which the effects of maternal separation are irreversible. Studies are notably lacking in this area, especially those that go beyond infancy.
4. It has been suggested that differing vulnerabilities at different periods of development might be determined, based on current knowledge of the developmental characteristics of children. The child's developmental level is likely to influence his reaction to deprivation or separation. With regard to separation, the period during which the child is in the process of consolidating a relationship with his mother may be the most vulnerable.[18] This area should be thoroughly explored, as well as the long-term effects of maternal deprivation and the irreversibility.
5. Studies such as Wolins's, which attempt to factor out the criteria associated with successful group care facilities, should be carried out and cross-validated One danger in cross-cultural research is that the measurement instruments may themselves be culture bound and what works in one culture might not succeed in another. To counter this problem, the following question seems appropriate: To what extent is it possible to factor out the cultural requisites for the success of a care model in a given culture? For example, what is the nature of the interplay between the kibbutz and the values, attitudes, and beliefs that inform the larger culture? Difficult as such research might be, it would begin to provide answers to the often-stated claim that it would never work in this culture.
6. Long-term comparative studies are needed of the differences in development and later adjustment of children reared in group care facilities and those reared in foster homes or in their own homes.
7. If, as seems to be the trend, more children will be candidates for group care facilities, how may the tasks of parenting be best divided among a number of different caretakers? What will be the role of the natural parent?
8. The question of rearing children away from their natural homes is an area already overburdened by polemics and tinged with political sensitivity. For this reason, researchers should proceed solely on the basis of evidence rather than on value orientations and preconceived hypotheses.

NATIONAL ORGANIZATIONS

Guidelines. National organizations like the Child Welfare League of America (CWLA) have played a key role in developing policy for child care institutions through the provisions of standards, consultation, research and demonstration, and publications. To serve the needs of the children's institutional field more effectively, the following guidelines are suggested:

1. A national organization (CWLA appears to be the logical choice) should act as a clearinghouse for all ongoing research in the areas of group care, maternal deprivation, institutionalization, separation from parents, and the like. This would involve the compilation of bibliographies, abstracts, and summaries as well as the publication of major studies, which would greatly remedy the idiosyncratic fashion in which studies are reported in the literature. National organizations should both encourage and publish repetitive studies to assure cross-validation of significant research and uncover studies that do not yield statistically significant results.

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[16] Kurt Glaser, "Implications from Maternal Deprivation Research for Child Welfare Practice," in *Maternal Deprivation: A Reassessment of Its Effects* (New York: Child Welfare League of America, 1964), p. 6.

[17] *See* Christopher M. Heinicke and Ilse J. Westheimer, *Brief Separations* (New York: International Universities Press, 1965).

[18] *See* Leon J. Yarrow, "Maternal Deprivation: Toward an Empirical and Conceptual Re-evaluation," *Psychological Bulletin*, Vol. 58, No. 6 (1961), pp. 459–490.

2. The federal government, through the Office of Child Development, should make funds available for research and demonstration projects on day care and group care facilities. This is crucial because the government's proposed policy will greatly expand day care, the organization and technology of which is little understood.

3. All national organizations—public and private—concerned with child care institutions should make a concerted attempt to assure that expanded services be accompanied by innovations and not just increase the number of existing services.[19] For example, because a specific technique (e.g., guided group interaction or psychiatric casework) or organizational form (e.g., the psychiatric team) appears to work with some children in certain settings is no reason to assume that a wholesale application of that technology or organization will eradicate the problem. National organizations in particular should be forums for innovations.

Implications for research. More than ever, adequate national statistics on all aspects of child welfare are needed to assure that program recommendations are actually meeting the needs of children.

1. All national organizations concerned with the child welfare field should deliver, collectively or individually, position papers on all federal legislation that affects the welfare of children. With specific reference to the Nixon welfare proposals, national organizations concerned with child welfare should make public statements regarding the feasibility of mounting an expanded day care program from the viewpoint of technology, organization, and existing manpower.

2. A national child welfare organization should assume leadership in the child advocacy field. It is becoming evident that a federal children's agency is not the best choice for this role, since it will probably be involved in the administration of the policies under question.

PARADOXES

The development of child welfare services in the United States over the past three hundred years is in a sense a reflection of this nation's commitment to its children. The degree that a people provides care, treatment, and rehabilitation for those children who cannot be served in their own homes is an indication—or perhaps an approximation—of their commitment and concern for the young in general. If this assumption is correct, then the historical data reveal more of a generalized ambivalence than a clearly defined set of values toward the child in this society. What emerges are a number of contradictory values and attitudes that are perhaps indicative of a cultural and ethnic diversity or represent a distinctly American phenomenon.

> *"The number of unserved needy children disputes the fact that this country cares about its young."*

From colonial times on, children, like adults, were supposed to be busy, productive individuals. Idleness and unproductivity were liablities in a frontier culture, and children who were poor, unruly, or orphans were expected to earn their keep in a charity school, orphanage, or reformatory. In the nineteenth century the work ethnic and the need for survival among some newly arrived immigrant children proved to be a source of consternation to the established society. "Street arabs," Brace called the newsboys, messengers, and numerous other young entrepreneurs who worked the streets of the large eastern cities in the middle and late 1800s. Forced to compete in the marketplace at an early age, many of these young "businessmen" were a cause of grave concern to people like S. A. Brooks of the New York Juvenile Asylum, who found no fault with the "smartness" and street sense of the boys he saw, but despaired at their lack of acceptance of society's values. In fact, they were in tune with the American ideal of bettering one's humble origins—by whatever means necessary.

Work—free labor really—was also seen as a motivating force behind the placing-out system: a child from the city meant another laborer on the farm. In delinquency institutions, work was and to an extent continues to be seen as a form of retribution for the delinquent act. Only recently have restrictive child labor laws been passed.

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[19] For example, in the recently completed Pappenfort study executives of child care institutions overwhelmingly voted that they would recommend "more-of-the-same" services if additional funds became available. *See* Donnell Pappenfort, Adelaide Dinwoodie, and Dee Morgan Kilpatrick, "Children in Institutions, 1966: A Research Note," *Social Service Review*, Vol. 42, No. 2 (June 1968), pp. 252–260; and Pappenfort and Kilpatrick, "Child Caring Institutions, 1966: Selected Findings from the First National Survey of Children's Residential Institutions," *Social Service Review*, Vol. 43, No. 4 (December 1969). pp. 448–459. The complete study is titled *Population of Children's Residential Institutions in the United States* (Chicago: Center for Urban Studies, University of Chicago, 1968). For additional statistical data *see* Shirley A. Star and Alma M. Kuby, *Number and Kinds of Children's Residential Institutions in the United States* (Washington, D.C.: U.S. Children's Bureau, 1967); Seth Low, *America's Children and Youth in Institutions 1950–1960–1964* (Washington, D.C.: U.S. Children's Bureau, 1964); and Wolins and Piliavin, op. cit., pp. 36–47.

Running counter to this notion of the child as "little adult" was the view of childhood as innocent and idyllic. For almost every trade that employed children in the nineteenth century, there was a society designed to protect the child from the "evil" master. At almost no time was the nation without vocal exponents of the belief that childhood was a time for carefree idleness, play, and unfettered enjoyment. In child care institutions, this was translated into a demand for recreation as a necessary part of the program and as a plea against the kind of tedious and uncreative tasks that had characterized many of the earlier institutious. These two forces are still much in evidence in the child welfare field and are observed in debates over the function of work in a child care institution and the kind of programs to which a child in a state-supported institution is "entitled."

Another idea about which society appears to be of two minds is the sacredness of the home. Despite the formal statement that "the home is the highest and finest product of civilization" and the only place where children may be properly reared, the actual practice in much of child welfare signifies the opposite. Welfare programs that cause families to be separated, bureaucratic procedures that condemn certain children to grow up in a dozen different settings until the proper agencies can decide who has jurisdiction and what the disposition should be, and unhomelike, sterile child care institutions make the formal pronouncement sound hollow.

Discrepancy

One also finds a discrepancy between the formally stated goals and policies of child care institutions and the actual services they offer. Although these institutions are ostensibly designed to care for, treat, or rehabilitate the dependent, delinquent, or emotionally disturbed child, much of their activities are related more to the needs of the professionals who staff them than to those of the children. Unlike the situation in the 1920s, we can now describe in detail the "function" of the various professional groups that operate in the child care institution, but are often hard pressed to characterize the relationship between these functions and the child's care or treatment.

If the needy child falls into the wrong category for aid, he faces serious difficulties. For example, the dependent-neglected and emotionally disturbed child or delinquent—mentally retarded child often is forced into the wrong slot simply because no facility exists for the "in-between" child. Similarly, some categories attract more public support and interest than others: physically handicapped and, more recently, mentally retarded children receive more public support than do emotionally disturbed or delinquent children. This difficulty is of course compounded if the child is poor and a minority-group member. Dewey's dictum that "what the best and wisest parent wants for its child, that must the community want for all of its children," has clearly not been adopted. A status hierachy exists even among needy children.

CONCLUSION

The number of unserved needy children disputes the fact that this country cares about its young—that it is willing to provide special help to those in need. The two-thirds (roughly one million) children needing psychiatric care,[20] the lack of public residential facilities for the soaring number of teen-age and subteen drug-users, and the woefully inadequate care facilities for delinquent and dependent-neglected children expose the extent to which this nation undervalues its children.

The lay community cannot be blamed entirely for this deplorable situation. What about the professionals who are so wedded to a specific child care technique that they cannot explore alternatives or who decry the abuses of public child care institutions, but steadfastly refuse to work for them, and the organization of services that places corrections, mental health, and child welfare in competition for the same tax dollars and personnel and precludes any meaningful joint ventures because of vested interests? Are they not at fault as well?

It is true that advances have been made in the children's institutional field since the turn of the century. The number of dependent children who were institutionalized for reasons of poverty alone has declined markedly over the last seventy years, standards for child care institutions have improved greatly, and no one can doubt the sincere and tireless efforts of countless professionals, laymen, and organizations who work diligently for the betterment of these institutions. Their efforts give heart to those who would continue the fight for improved child welfare services.

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[20] *See Crisis in Child Mental Health*, p. 5.

Yet the careful observer of the historical development of child-care institutions cannot help but be impressed with the nation's ability to diagnose the problem in countless commissions, child welfare conferences, and foundation reports but its apparent inability—or unwillingness—to bring about significant and lasting change. Perhaps what is needed most—and what is least likely to come—is a national conviction that the young are truly the nation's most valuable resource and, as such, should assume the highest priority in terms of allocation of funds and talented personnel. To do otherwise—particularly in terms of those children who need special care away from home—is to invite those who are publicly ignored in their formative years to make their "voices" heard in rising crime statistics, increasing mental hospital populations, growing numbers of disrupted families in need of welfare, and the street violence and anomie born of an intense frustration that there is no way out. The prospects for such a radical turn of mind are dim indeed when one realizes that this nation—by and large—continues to see its most formidable enemies as coming from without—not from within.

"Adolescent Patients Served in Outpatient Psychiatric Clinics"
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Adolescents are the largest users of psychiatric outpatient clinics in the United States. This paper presents findings obtained in a detailed study of the use of these facilities by members of this age group (10-19). Implications for program development are discussed.

ADOLESCENT PATIENTS SERVED IN OUTPATIENT PSYCHIATRIC CLINICS

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OUTPATIENT psychiatric clinics in the United States serve more persons in the 10 through 19-year-age group than in any other decade of life.[1,2] Of the total estimated 750,000 clinic patients served in 1962, approximately one-fourth, or 194,000, were adolescents.[3] This number represented about 6.2 patients per 1,000 adolescents in the population.

Despite the increasing number of clinics in this country and the concomitant increase in the number of adolescents served (17 per cent from 1961 to 1962), first admission rates to state and county mental hospitals for children in these ages have increased at an even greater rate.[1,4] The effective utilization of clinic services by schools, physicians, and social agencies, as well as by families of adolescents, is essential if the admission rate to mental hospitals is to be reduced, and if sufficient services are to be provided to the substantially larger number of children who will reach adolescence during the next decade.[5]

This paper will present findings of a detailed study of the current utilization of psychiatric clinic services by adolescent patients. Interpretation of these data in terms of psychological development of the adolescent and implications for program development, particularly among schools and public health nursing personnel, also will be discussed.

This study was carried out by the National Institute of Mental Health with the cooperation of State Mental Health Authorities. Special tabulations, prepared by 41 states included 788 clinics and 54,000 adolescents for whom services were terminated in 1962, or about half of the 104,000 adolescent clinic terminations in the United States.[6] The largest omission was for New York State which accounted for 28 per cent of all adolescent patients.

Data were reported on diagnosis, sources of referral, type and amount of service, and disposition, by sex and two-year-age groups. Although the data are for terminated patients, they are generally descriptive of clinic admissions because of the short duration of clinic services for most patients.[7]

Patient Characteristics

Age and Sex

Figure 1 shows an unequal distribution in the number of adolescent patients over the ten-year range; the largest proportion was the 14-15-year-

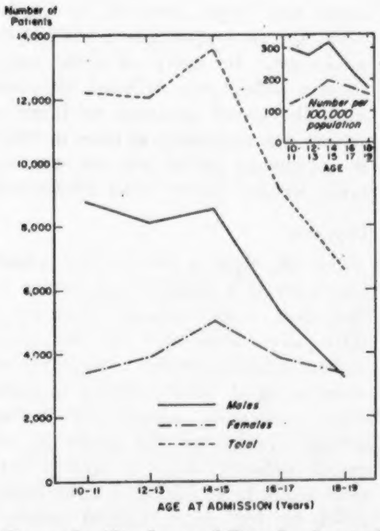


Figure 1—Number and Rate by Age and Sex, Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962.

olds and the smallest, the 18-19-year-olds. The sex ratio decreased with age from 2.6 boys to each girl at 10-11 years to about the same number in each sex group at 18-19 years. The clinic utilization pattern by age and sex is similar when calculated as a rate (number of patients per 100,000 civilian population) (Figure 1).

Mental Disorders

The disorders with greatest impairment (brain syndromes, mental deficiency, and psychotic disorders) as a group were reported far less frequently than the less severe disorders (personality disorders, transient situational disorders, psychophysiologic disorders, and psychoneuroses)—16 per cent of all patients with the more severe disorders, and 60 per cent, the less severe (Table 1). Overall, 3 per cent of the adolescents were diagnosed as without mental disorder while 20 per cent were reported as undiagnosed. The proportion undiagnosed was 30 per cent of the untreated, but only 1 per cent of the treated patients.

Decreasing relative frequencies with age were reported for the following disorders (Figure 2): brain syndromes, mental deficiency without known organic cause, and transient situational disorders which showed a particularly sharp drop in the late teens. In contrast, the following were diagnosed relatively more frequently among older adolescents and showed sharp increases in the late teens: personality disorders, psychotic disorders, and psychoneuroses (for girls only).

Convulsive disorder was the most frequent brain disorder throughout the adolescent years, but particularly in younger ages (Table 1). Schizophrenic reaction, childhood type, was predominant among younger psychotics, and chronic undifferentiated type among older ones. Anxiety reaction was the most common psychoneurotic disorder; however, depressive reactions increased in frequency with age among girls, becoming almost as frequent as anxiety reactions. Passive aggressive disorder was the principal personality diagnosed. Schizoid personality was relatively more frequent among older boys than younger boys, and emotionally unstable personality among older girls.

Referral Source

The school was the predominant referral agent for both boys and girls from 10 through 15 years of age (see Figure 3). Referrals by private physicians or self, family or friends, were also relatively frequent for young girls and for both boys and girls in the late teens. For adolescents from 14 to 17 years of age, particularly boys, courts were also a frequent source of referral.

Services Received

Proportion Treated

Overall, only a third of all adolescent patients were treated; the remaining two-thirds received only intake or other diagnostic services including evaluation for other agencies (Figure 4a). The proportion treated generally increased with age, from about 31 per cent for those less than 15 years to 38 per cent for 18-19-year-old boys and 48 per cent for the older girls. Those referred by family, friend, or by private physician generally were more likely to receive treatment than patients referred by community agencies.

Relatively high proportions of the following patient groups were treated: psychoneurotics, older psychotics, younger convulsive patients, those with psychophysiologic disorders, and older boys with schizoid personality (Figure 4b). Relatively few mental retardates received treatment services.

Number of Person-Interviews

The median number of interviews for all adolescent patients was four (Table 2). About a fourth received from five to nine interviews and 10 per cent, 25 interviews or more (long-term treatment). The median was considerably higher for treated than untreated patients, 14 compared with three.

Judging by the number of interviews, treated boys received somewhat more service than did treated girls in all but the oldest age group (Figure 5). The median number of interviews for both boys and girls also was considerably higher for the younger than the older patients. In part, the larger number of person interviews for younger patients reflects the greater involvement of parents, or other significant persons in the services provided to the younger adolescent (Table 3), since each person present at an interview is counted.

In approximately 10 per cent of all cases and 1 per cent of the treated cases, the parents were seen without the adolescent. In many of these cases, parents either were referred elsewhere after the initial interview or failed to return. The proportion of cases in which the adolescent patient was not seen was much smaller among older adolescents.

Disposition

Overall, about a third of the adolescent patients withdrew from service on their own or their parents' initiative, a third were terminated by the clinic without referral elsewhere, while the remaining third were referred to some other community agency for further service (Table 4a). As might be expected, patients who were treated were more likely to withdraw or to be terminated by the clinic without referral, than were nontreated patients.

Rates of self-termination and of termination by clinic without referral were generally higher for girls than for boys. With increasing age, the rate of self-termination for both sexes increased while that of nonreferral decreased. The peak ages for referrals to other agencies for further care were during the middle adolescent years.

The more serious cases (brain syndromes, mental deficiencies, and psychotic disorders) tended more than others to be referred to other community agencies and institutions rather than to receive alternative dispositions (Table 4b). For the mentally deficient patient, the school was not only the principal pathway to the clinic, but also the agency to whom the patient was referred for further service. The principal agency to which patients with brain syndromes and psychotic disorders were referred was the inpatient facility; for psychoneuroses, most frequently other outpatient facilities but also social service agencies and, at older ages, inpatient facilities. The major agencies to which referrals were made for those

Table 1—Diagnostic Category by Age and Sex, Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962.

(Distribution of Detailed Disorders Based on Information Received from 586 Clinics)

Major and selected detailed disorder	Males						Females					
	Total	Age at admission					Total	Age at admission				
		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years
Total number of patients	34,007	8,770	8,123	8,557	5,328	3,229	19,667	3,488	3,960	5,035	3,855	3,329
Percent distribution												
Acute and chronic brain disorders	3.6	5.1	3.8	3.0	2.3	2.5	2.8	4.6	3.6	2.1	2.0	1.8
Associated with or due to:												
Prenatal conditions	.3	.3	.2	.3	.3	.4	.3	.6	.3	.2	.2	*
Trauma	.7	.8	.7	.6	.6	.5	.3	.3	.5	.3	.3	.2
Convulsive disorder	.9	1.1	1.0	.8	.6	.9	1.0	1.5	1.4	.8	.6	1.1
All other	.4	.5	.5	.4	.2	.4	.3	.5	.4	.2	.4	.3
Unknown or unspecified cause	1.3	2.4	1.4	.9	.6	.3	.9	1.7	1.0	.6	.5	.2
Mental deficiency	7.9	8.3	8.9	8.5	7.0	3.9	7.9	12.0	10.8	8.1	4.9	3.4
Mild	3.6	4.1	4.0	3.8	2.8	1.7	3.4	4.8	4.5	3.5	2.4	1.4
Moderate	3.1	2.9	3.6	3.5	2.7	1.3	3.2	5.0	4.8	3.2	1.8	1.3
Severe	1.0	1.2	1.0	1.1	1.1	.6	1.1	1.8	1.3	1.2	.6	.6
Severity not specified	.2	.1	.3	.1	.4	.3	.2	.4	.2	.2	.1	.1
Psychotic disorders	4.4	1.7	2.4	3.7	7.2	14.2	5.7	2.2	2.7	4.8	7.0	12.8
Schizophrenic reactions:	4.3	1.6	2.4	3.6	7.1	13.8	5.5	2.2	2.5	4.7	6.8	12.2
Paranoid type	.8	*	.2	.6	1.8	3.5	.8	.1	.2	.6	1.0	2.0
Acute undifferentiated type	.5	.1	.1	.5	.9	1.9	.9	.1	.3	.7	1.3	2.3
Chronic undifferentiated type	1.2	.1	.5	1.1	2.0	4.8	1.4	.3	.4	1.0	1.8	4.0
Childhood type	.9	1.2	1.2	.6	.3	.2	.7	1.5	1.0	.7	.6	.1
Other and unspecified	.9	.2	.4	.8	2.0	3.4	1.7	.2	.6	1.7	2.1	3.8
All other psychotic disorders	.1	.1	*	.1	.1	.4	.2	*	.2	.1	.2	.6

Psychophysiologic autonomic and visceral disorders	.6	.7	.6	.5	.6	1.0	1.2	1.7	1.0	.9	1.0	1.4
Psychoneurotic disorders	8.8	10.8	9.0	7.3	6.9	10.2	13.9	11.8	12.3	11.7	14.0	21.0
Anxiety reaction	4.1	5.3	4.1	2.9	2.8	5.0	4.7	5.0	3.9	3.2	4.2	7.9
Obsessive compulsive reaction	.9	1.0	.9	.8	.8	.9	.8	.6	.7	.8	.9	1.0
Depressive reaction	1.4	1.0	1.2	1.5	1.6	2.5	3.3	1.2	1.5	2.6	4.0	7.6
Other	2.4	3.5	2.8	2.1	1.7	1.8	5.1	5.0	6.2	5.1	4.9	4.5
Personality disorders	23.5	18.9	21.8	25.0	27.3	29.8	18.2	12.9	16.3	18.7	19.5	23.8
Personality pattern disturbance:	5.4	2.9	3.7	6.2	7.4	9.9	4.7	2.7	3.6	5.5	5.2	6.5
Inadequate personality	1.1	.5	.8	1.3	1.6	1.8	1.4	.3	.6	2.0	1.3	2.2
Schizoid personality	3.3	1.5	2.1	3.9	4.8	6.7	2.4	1.5	2.2	2.5	2.9	3.2
Other	1.0	.9	.8	1.0	1.0	1.4	.9	.9	.8	1.0	1.0	1.1
Personality trait disturbance:	12.1	10.8	12.4	12.8	12.6	12.3	10.1	7.2	9.4	9.5	10.7	14.1
Emotionally unstable personality	1.8	1.1	1.5	2.0	2.2	2.9	3.0	1.3	1.9	2.6	4.3	4.6
Passive-aggressive personality	8.9	8.3	9.4	9.4	9.2	7.8	5.5	4.5	5.9	5.6	4.8	7.4
Other	1.4	1.4	1.5	1.4	1.2	1.6	1.6	1.4	1.6	1.3	1.6	2.1
Sociopathic personality disturbance:	3.7	1.4	2.5	4.5	6.2	6.8	2.2	.4	1.3	3.0	2.9	2.8
Antisocial reaction	2.3	.9	1.8	2.9	4.1	3.0	1.4	.3	1.0	1.8	1.5	1.7
Dyssocial reaction	.6	.3	.5	.8	.6	.5	.6	.1	.3	1.0	1.0	.6
Sexual deviation	.8	.2	.2	.8	1.5	3.0	.2	–	*	.2	.4	.4
Other	*	*	*	*	*	.3	*	–	*	–	*	.1
Special symptom reaction:	2.3	3.8	3.2	1.5	1.1	.8	1.2	2.6	2.0	.9	.7	.4
Learning disturbance	1.4	2.4	2.1	.9	.5	.1	.6	1.4	1.1	.3	.3	.1
Other	.9	1.4	1.1	.6	.6	.7	.6	1.2	.9	.6	.4	.3
Transient situational personality disorders	28.4	31.9	30.8	29.1	25.9	14.9	27.9	30.7	30.4	31.7	28.7	15.2
Without mental disorder	3.0	2.3	2.8	3.3	3.8	3.0	2.7	2.6	2.9	3.0	2.4	2.2
Undiagnosed	19.8	20.4	19.9	19.5	18.8	20.5	19.8	21.5	20.0	19.0	20.4	18.4

* Less than 0.05.

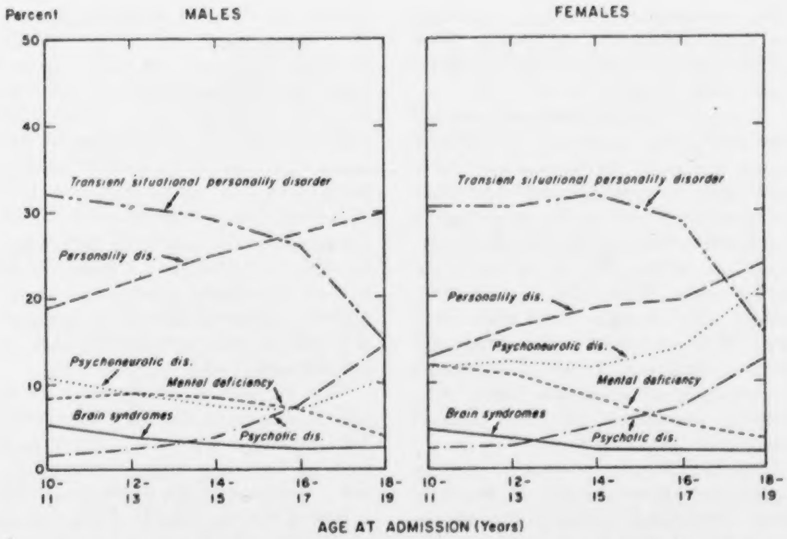


Figure 2—Per cent Distribution by Major Diagnostic Category, Age and Sex, Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962

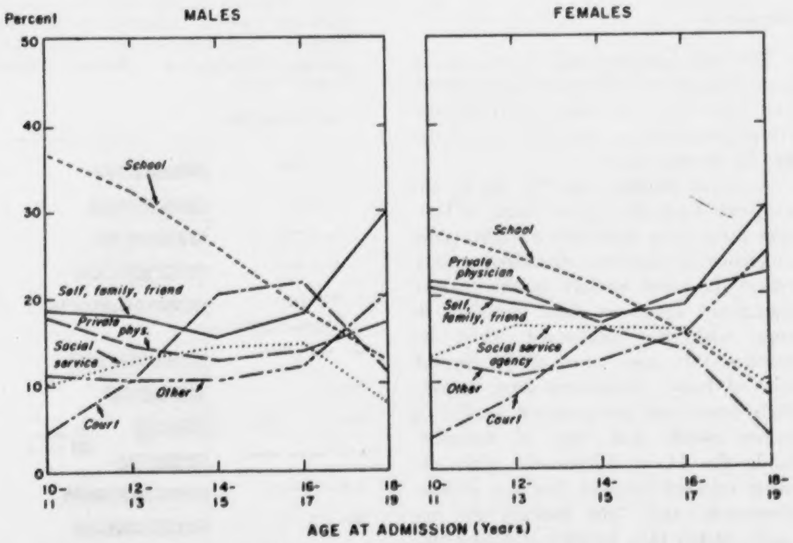


Figure 3—Per cent Distribution by Referral Source, Age and Sex, Adolescent Patients Terminated from 780 Outpatient Psychiatric Clinics, United States, 1962.

with personality disorders, including transient situational disorders, were courts and correctional units, and for girls, social agencies.

In general, patients who were referred by community agencies, particularly courts and social service agencies, were least likely to withdraw and most likely to be referred back to the same agency for further care, a reflection of the frequent use of the clinic as an evaluating service only (Table 4c). In contrast, family and physician referrals were more likely to result in the withdrawal of those clinic services which terminated in treatment or referral to some other type of psychiatric or other medical agency for further service.

Treated patients receiving relatively large numbers of interviews generally were terminated without referral, as might be expected. If not, they most frequently were referred to either outpatient psychiatric services or to social service agencies (Figure 5).

Discussion

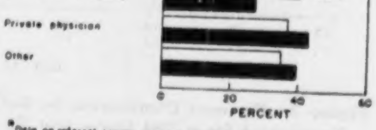
The findings presented in this study lend themselves to several interpretations, and may give us some clues for developing programs uniquely suited to the adolescent years.

A major finding, that the 14 to 15-year-olds have the highest clinic utilization rates, may represent a higher true incidence of emotional disorders or may reflect increased anxiety on the part of significant adults at their inability to cope with the adolescent when he reaches this age, particularly in the case of boys. Adolescent boys express their inter- and intrapersonal conflict in sullen moods and acts of defiance, while the 14 or 15-year-old girls are often referred because they are listless, depressed, and "not making it" socially, rather than because of acting out.

The consistently higher rates for boys than girls in mid-adolescent years correspond with their relatively high rate of "appearance" at other "trouble handling" agencies—the police, juvenile court, the principal's office.[8,9] The clinic may be used by school, police, and court personnel as an extension of their attempts to control or modify behavior, particularly of mid-adolescent boys. Though the clinic may relieve the child's disturbance, despondency, and anger, his behavior often is in response to the lack of meaningful educational or job-training opportunities and of a satisfying role in the community, thus requiring society-wide action.

Now let us look at the drop in the rates for boys in the later teen years. This probably reflects not fewer problems or lessening anxiety among boys, but a decrease in the forces compelling a boy to stay in school. After the age of 16, the school can use or threaten expulsion as a means of controlling be-

Figure 4a—Per cent of Patients Who Were Treated, by Age and Sex and by Referral Source* and Sex, Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962.



*Data on referral source reported for 780 clinics

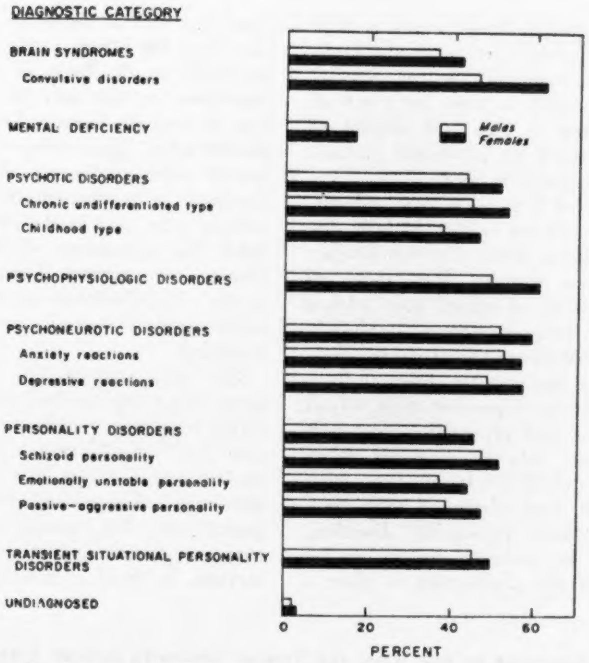


Figure 4b—Per cent of Patients Who Were Treated, by Diagnostic Category and Sex, Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962.

havior. Further, the need to appear independent and self-sufficient in order to live up to the masculine image makes it more difficult for the older adolescent boy to seek or accept help.

On the other hand, girls, whose clinic rates change little during adolescent years, are permitted by our culture to accept help more readily (and as statistics for adult clinic patients show, do so in even greater numbers when they become young women).[2] Our study indicates also that during the later adolescent years, anxiety and depression reactions increase in girls. This may be due in part to the pressure of having to make life choices, such as whether or not to go to college, seek vocational training, work, or get married.

It should be noted here that the drop in rates at 18 to 19 years of age reflects the utilization of psychiatric clinic services only. Mental health services received by this age group in college health or counseling units are not included in these data.

At this point we might mention another interpretation of differences in the characteristics of patients: the selection by the clinic of clientele which they feel respond best to the kind of service offered. Psychotherapy requires considerable commitment and participation on the part of the patient, often over an extended period of time. Those patients who are preoccupied with self-examination and willing to talk about themselves best fit the requirements of the psychotherapeutic regime. These factors, in addition to the patient's pathology and kinds of services requested by the referral agency, probably account for much of the difference in type and amount of service received by adolescent patients and the dispositions made.

As reflected from these data, schools, as a major referral agency, identify disturbed children, many of whom develop more serious illnesses when they are older. A study of school male adolescents who later became schizophrenic indicates that these students were recognized to be significantly different from a control group of peers in skills, school adjustments, and personality characteristics.[10] Our data on diagnosis shows that until age 18, the largest proportion of patients were diagnosed with transient situational personality disorders. This may be partially due to the reluctance of the psychiatrist to place a label of a serious disorder on a youngster when his identity may be in flux, especially on the basis of only a few interviews, or this may be due to the lack of adequate technics for such early identification. The increase in the number of older adolescents diagnosed as psychotic or psychoneurotic may indicate, in part, that as the patient grows older, the seriousness of his disorder becomes more evident. Further research in the early identification of potentially serious mental disorders in adolescents is needed.

Our data suggest that parents are more frequently involved in service received by younger adolescents. Another area for further investigation concerns the differences, if any, in the length and type of service received related to the parent seen. For example, if both parents are present during the intake interview, is there a greater chance of

Table 2—Interviews by Age, Total and Treated Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962

Person-interviews	Total	Age at admission				
		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years
Total number of patients	53,674	12,258	12,083	13,592	9,183	6,558
Percent receiving:						
1 interview	16.0	13.4	13.9	15.7	17.4	23.0
2 interviews	15.6	12.9	14.3	15.9	17.7	19.7
3 - 4 interviews	19.5	18.1	18.5	20.7	20.3	20.1
5 - 9 interviews	24.0	25.6	25.2	24.9	22.5	18.7
10 - 24 interviews	14.7	15.7	16.0	14.4	13.9	12.3
25 or more interviews	10.2	14.3	12.0	8.4	8.0	6.1
Median	4	6	5	4	4	3
Number of treated patients	17,795	3,984	3,840	4,017	3,139	2,815
Percent receiving:						
1 interview	2.3	0.9	1.5	1.3	2.6	6.3
2 - 4 interviews	11.9	6.8	7.1	10.2	14.6	24.7
5 - 9 interviews	22.1	17.5	18.0	23.2	26.1	27.8
10 - 14 interviews	16.0	14.5	16.7	17.7	16.3	14.5
15 - 19 interviews	10.2	9.7	10.8	11.6	10.2	8.1
20 - 24 interviews	7.2	7.8	8.4	7.9	6.8	4.3
25 or more interviews	30.3	42.9	37.5	28.0	23.3	14.2
Median	14	20	18	14	12	8

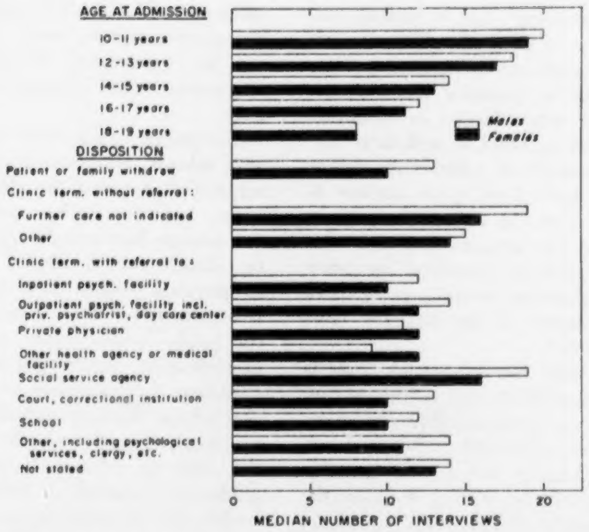


Figure 5—Median Number of Person-Interviews Received by Treated Patients, by Age and Sex and by Disposition and Sex, Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962.

treatment? If the father is involved, is there any difference in service or outcome?

The implications of the self-termination rate (one-third of all adolescents) require further study, as does also the actual postclinic experience of all patients. A useful approach to the evaluation of clinic services to adolescents is through the collection of longitudinal information on the patient's psychiatric characteristics, and on services received. Such information, now being obtained systematically through psychiatric case registers,[11] should yield useful clues on the effective role of the clinic in the patient's total psychiatric life experiences.

These data may serve as a basis for re-evaluating "impressions" regarding acceptability of certain types of cases. For example, court referrals, often considered uncooperative, show no higher withdrawal rates than other cases when referred for treatment.

What are the program implications of our data? Pressures for decision continue to increase during adolescence. These pressures may be relieved somewhat through the development of programs in schools through which children can learn to handle stress more adequately.[12] As an example, for those going on to college an anticipation of what they will encounter on the campus can go a long way toward reducing anxiety, easing transition, and thus perhaps reducing college freshmen dropouts. Similarly, the trade or work-bound youngster can be assisted in self-acceptance of a less socially esteemed role.

These data indicate that the schools are the primary source of referrals to clinics. This role cannot be overemphasized. The school has a unique advantage in relating to virtually all adolescents and thus being able to identify existing or potential disturbances. Schools are very effective in encouraging a family or child to seek help. Delays in referral of adolescents, whose difficulties have been quite obvious to the school from the age of 10 or 11 or earlier, must be avoided if serious disturbances are to be prevented. By senior year of high school, in some areas, more than a quarter of the students have dropped out.[13]

Once a child has left school, there is no institution which has continuing contact with or responsibility for him. Whether or not the older adolescent will seek help later on will depend upon his own sense of discomfort, or upon the development of obvious and disturbing psychopathology which may result in conflict with the law and other social institutions. The public health nurse in her general nursing work with families can be instrumental in referring the adolescent school dropout in need of help.

The public health nurse in her work with schools, traditionally serving as a major link between the school and the home, and the teacher and the child, can become increasingly concerned with the child's mental health, particularly as physical health problems decrease. A variety of services can be provided by the public health nurse, such as case identification, family counseling, health guidance, interpretation of the adolescent's home situation and developmental problems, liaison with the school and the clinic in relation to and with the adolescent in trouble. Although public health nursing services are available to many school systems, either formally or informally, much more can be done to

Table 3—Person Interviewed, by Age of Patient, Total and Treated Adolescent Patients Terminated from 754 Outpatient Psychiatric Clinics, United States, 1962

Person seen (interviewed)	Total	Age at admission				
		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years
Total number of patients	51,537	11,759	11,546	12,990	8,809	6,433
Percent of patients by interviews with:						
Patients only	22.1	9.9	12.7	17.9	28.7	61.2
Patient, parent(s) only	50.6	60.7	57.4	52.3	45.6	23.8
Patient, parent(s), others	11.9	13.4	13.8	13.1	11.0	4.7
Patient, others only	5.7	3.5	4.7	6.4	7.2	8.1
Parent(s), others only	.7	.8	.7	.7	.6	.2
Parent(s) only	8.7	11.6	10.5	9.3	6.6	1.8
Others only	.2	.1	.2	.3	.3	.2
Number of treated patients	16,756	3,734	3,573	3,743	2,971	2,735
Percent of patients by interviews with:						
Patients only	21.1	4.8	7.9	14.1	28.6	62.0
Patient, parent(s) only	59.3	73.5	70.3	65.8	52.9	23.6
Patient, parent(s), others	14.6	18.4	18.2	15.6	12.6	5.6
Patient, others only	4.0	1.9	2.4	3.6	5.2	8.5
Parent(s), others only	.2	.2	.3	.1	.1	.1
Parent(s) only	.7	1.1	.8	.6	.4	.3
Others only	.1	.1	.1	.2	.2	-

Table 4a—Disposition by Age, Total and Treated Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962

Disposition	Total	Age at admission				
		10-11 years	12-13 years	14-15 years	16-17 years	18-19 years
Total number of patients	53,674	12,258	12,083	13,592	9,183	6,558
Percentage distribution:						
Patient or family withdrew	31.2	29.7	28.7	29.3	31.9	41.8
Clinic terminated without referral:						
Further care not indicated	22.1	26.8	23.1	19.6	19.0	20.8
Other	8.2	8.5	8.1	8.5	8.3	6.8
Clinic terminated with referral to:	31.4	28.3	32.6	35.0	32.9	25.7
Inpatient psychiatric facility	5.7	3.7	5.1	5.8	7.3	8.2
Outpatient psychiatric facility, incl. private psychiatrist, day care center	3.4	3.2	3.3	3.0	3.6	4.8
Private physician	1.6	1.9	2.0	1.2	1.3	1.7
Other health agency or medical facility	1.5	2.2	1.5	1.1	1.2	1.4
Social service agency	6.4	5.8	7.2	7.6	6.8	2.6
Court, correctional institution	5.6	2.0	4.7	9.0	7.9	3.7
School	5.6	8.2	7.4	5.9	2.6	1.1
Other (incl. psychological services, clergy, etc.)	1.6	1.3	1.4	1.4	2.2	2.2
Not stated	7.1	6.8	7.3	7.5	7.9	5.0
Number of treated patients	17,795	3,984	3,840	4,017	3,139	2,815
Percentage distribution:						
Patient or family withdrew	39.4	34.0	34.0	39.2	44.0	49.3
Clinic terminated without referral:						
Further care not indicated	32.2	41.1	34.9	30.6	26.6	24.0
Other	8.7	7.8	9.9	9.4	9.0	7.2
Clinic terminated with referral to:	15.8	13.6	17.8	17.0	16.1	15.0
Inpatient psychiatric facility	4.5	2.4	3.9	4.4	5.7	7.1
Outpatient psychiatric facility, incl. private psychiatrist, day care center	2.6	1.7	2.6	2.2	2.8	4.2
Private physician	1.0	1.3	1.4	.7	.8	.8
Other health agency or medical facility	.7	.9	.7	.5	.6	.8
Social service agency	1.9	2.3	2.8	2.0	1.7	.5
Court, correctional institution	1.8	.9	2.0	3.2	2.4	.4
School	2.4	3.3	3.5	3.0	1.0	.2
Other (incl. psychological services, clergy, etc.)	.9	.8	.9	1.0	1.1	1.0
Not stated	3.8	3.2	3.5	3.8	4.1	4.5

Table 4b—Disposition by Major Diagnostic Category, Total and Treated Adolescent Patients Terminated from 788 Outpatient Psychiatric Clinics, United States, 1962

Disposition	Total	Major diagnostic category: Brain syndromes	Mental deficiency	Psychotic disorders	Psycho-physiologic disorders	Psycho-neurotic disorders	Personality disorders	Transient situational personality disorders	Without mental disorder	Undi-agnosed
Total number of patients	53,674	1,766	4,238	2,926	451	5,722	11,560	15,142	1,532	10,637
Percentage distribution:										
Patient or family withdrew	31.2	17.6	8.1	33.3	40.1	37.3	29.7	32.7	8.8	43.3
Clinic terminated without referral:										
Further care not indicated	22.1	16.8	18.8	8.7	21.7	23.5	19.0	29.0	36.9	17.8
Other	8.2	6.7	6.0	6.2	10.0	9.8	9.9	8.7	4.5	6.5
Clinic terminated with referral to:	31.4	53.4	57.5	47.1	22.2	21.6	34.4	23.5	41.7	24.6
Inpatient psychiatric facility	5.7	14.8	11.6	32.2	2.4	4.5	4.5	1.8	.8	2.8
Outpatient psychiatric facility, incl. private psychiatrist, day care center	3.4	4.1	1.6	4.9	3.1	4.9	3.3	2.9	.8	4.3
Private physician	1.6	8.2	1.9	1.5	6.2	1.5	1.1	1.1	1.8	1.5
Other health agency or medical facility	1.5	8.0	3.8	1.0	2.7	.8	1.0	.8	2.9	1.1
Social service agency	6.4	4.4	12.4	2.6	3.8	3.7	6.3	6.0	22.5	4.9
Court, correctional institution	5.6	2.7	6.1	2.2	1.1	2.5	11.7	5.2	3.7	2.7
School	5.6	8.8	18.3	1.4	2.0	2.4	4.5	4.6	8.2	5.2
Other (incl. psychol. services, clergy, etc.)	1.6	2.4	1.8	1.3	.9	1.3	2.0	1.1	1.0	2.1
Not stated	7.1	5.4	9.6	4.9	6.0	7.7	7.0	6.1	8.2	7.7
Number of treated patients	17,795	658	505	1,219	246	3,120	4,649	7,044	124	230
Percentage distribution:										
Patient or family withdrew	39.4	29.9	24.6	37.4	43.5	41.3	42.2	39.0	25.0	41.3
Clinic terminated without referral:										
Further care not indicated	32.2	22.5	27.3	15.0	32.5	33.0	27.3	38.8	47.6	33.5
Other	8.7	6.5	6.3	7.2	8.1	8.6	11.0	8.0	9.7	5.7
Clinic terminated with referral to:	15.8	38.0	38.6	36.4	12.8	12.1	15.9	10.5	15.2	16.3
Inpatient psychiatric facility	4.5	13.4	12.1	25.6	1.6	2.6	3.3	1.2	1.6	4.3
Outpatient psychiatric facility, incl. private psychiatrist, day care center	2.6	4.3	2.0	5.6	2.0	2.9	2.4	2.0	2.4	1.3
Private physician	1.0	8.5	1.2	.8	2.4	1.1	.6	.6	-	.4
Other health agency or medical facility	.7	4.3	3.0	.4	1.5	.6	.5	.4	4.8	.4
Social service agency	1.9	2.4	2.2	1.4	1.6	1.9	2.2	1.8	1.6	2.6
Court, correctional institution	1.8	1.2	2.0	.6	1.2	.8	3.4	1.5	1.6	3.0
School	2.4	3.0	14.5	.8	1.6	1.5	2.2	2.3	2.4	2.6
Other (incl. psychol. services, clergy, etc.)	.9	.9	1.6	1.2	.8	.7	1.3	.7	.8	1.7
Not stated	3.8	3.0	3.4	3.9	2.8	4.9	3.8	3.5	2.4	3.0

Table 4c—Disposition by Referral Source, Total and Treated Adolescent Patients Terminated from 780 Outpatient Psychiatric Clinics, United States, 1962

Disposition	Total	Referral source Self, family, friend	School	Court	Social service agency	Private physician	Other
Total number of patients	52,970	10,337	13,116	6,337	6,892	8,933	6,851
Percentage distribution:							
Patient or family withdrew	31.4	38.9	31.6	20.5	19.7	37.4	32.1
Clinic terminated without referral:							
Further care not indicated	22.1	28.3	22.7	14.3	19.1	23.1	21.2
Other	8.2	9.0	7.9	8.0	6.7	7.7	10.1
Clinic terminated with referral to:	31.5	18.8	20.0	50.7	45.8	24.9	32.9
Inpatient psychiatric facility	5.7	4.5	3.7	7.6	6.3	5.7	8.8
Outpatient psychiatric facility, incl. private psychiatrist, day care center	3.4	4.0	2.8	2.0	1.7	4.3	5.7
Private physician	1.6	1.1	1.0	.3	.5	5.4	1.1
Other health agency or medical facility	1.5	.6	.7	.4	2.5	2.3	3.3
Social service agency	6.4	2.4	2.6	4.1	29.8	2.4	3.7
Court, correctional institution	5.6	1.2	2.4	33.9	1.8	.9	2.6
School	5.7	3.4	14.5	1.4	1.6	2.6	4.5
Other (incl. psychological services, clergy, etc.	1.6	1.6	1.3	1.0	1.6	1.3	3.2
Not stated	6.7	5.0	8.9	6.6	8.5	6.8	3.6
Number of treated patients	17,205	3,986	3,870	1,367	1,616	3,530	2,501
Percentage distribution:							
Patient or family withdrew	40.2	40.3	38.5	39.0	36.9	42.1	39.7
Clinic terminated without referral:							
Further care not indicated	32.8	36.7	36.3	27.6	28.3	33.7	27.5
Other	8.8	8.3	9.2	9.5	9.4	7.7	10.2
Clinic terminated with referral to:	14.7	11.2	13.3	21.9	18.5	12.2	19.9
Inpatient psychiatric facility	4.2	3.3	2.7	4.4	4.0	3.7	8.1
Outpatient psychiatric facility, incl. private psychiatrist, day care center	2.5	2.3	1.5	1.7	2.4	2.5	4.7
Private physician	1.0	1.0	.8	.2	.6	1.9	.8
Other health agency or medical facility	.5	.3	.5	.2	.7	.5	1.1
Social service agency	1.8	1.2	1.3	2.1	6.6	1.2	1.5
Court, correctional institution	1.7	.9	.9	10.9	1.9	.7	.7
School	2.1	1.4	4.9	1.5	1.1	1.0	1.5
Other (incl. psychological services, clergy, etc.)	.9	.8	.7	.9	1.2	.7	1.5
Not stated	3.6	3.6	2.6	2.0	6.9	4.4	2.8

develop this valuable professional resource.

Finally, a major area for further development concerns coordination of activities between clinic and school. Both must be aware of the limits and responsibilities of each other's role in preparing the child for adulthood. To this end, increased communication between school and clinic with regard to specific children can be fostered. In addition, the school in its role as a social system, by modifying its practices, by teaching stress management, perhaps can alleviate some of the anxiety during the adolescent years and make a greater contribution to the maturation of youth.[14] The clinic, through its consultative activities, might apprise the school more systematically and effectively on the psychological needs and problems of all children during these years. The location of clinic teams in the schools on a regularly scheduled basis may provide the necessary organizational structure for both direct service and consultation. The ready availability of such a service may avert the large proportion of clinic and school dropouts.

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State of Massachusetts Department of Youth Services:

a) Background on the Massachusetts Department of Youth Services
b) Perspective on History and Strategy for Phasing Out State Juvenile Institutions
c) Brief Description of Funded Proposals to Establish Community Based Treatment Units
d) Act of 1969—Chapter 838, establishing Department of Youth Services

I. STATE OF MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES

(A) BACKGROUND INFORMATION ON THE DEPARTMENT OF YOUTH SERVICES

Every year, the juvenile courts of the Commonwealth of Massachusetts commit 1,200 to 1,300 children between the ages of seven and seventeen to the care of the Department of Youth Services. Some of these children are well known to the clinical staff of the Department—they have been through the commitment process many times before. Others are new to the juvenile justice system, arriving at the Department freshly labelled a delinquent, a runaway, a car thief, a "stubborn child". It is the goal of the Department of Youth Services to provide every child in its care with the best treatment available to insure that he will never again be in trouble with the law and to help him make a successful readjustment to society.

Who are the Department's children? Almost universally, they are the offspring of Massachusetts' poor. Their parents are generally unschooled and unskilled, sporadically employed, chronically depressed, and emotionally immature. Many of the parents have severe drinking problems, some have histories of emotional illness, several have criminal records. Well over half of the parents have been divorced, separated, or deserted. The homes of the children are characterized by disorder and confusion. No more than 40% of these children come from intact homes. At least 25% are living with their mothers only. Poor performance in school is common, although most of the children test within the normal range of intelligence. Many present a behavior problem in school. Some are "battered" children, having suffered broken bones, brain damage, or severe burns at the hands of an irate parent. A complete lack of medical and routine dental care is often noted. In fact, a few children reach the Department suffering from malnutrition. Some have been bounced from one social welfare agency to another for years until a deviant act or a complaint brought by the parents to the courts results in commitment to the Department. Many of the children have a problem with drugs; some have deep-seated emotional disturbances stemming from parental neglect or abuse; a few of the girls are pregnant; a few are mentally retarded. Almost none of the families of these children can afford the services they need.

At the present time, the Department is closing down the large institutions across the state which have traditionally housed committed and court-detained children. Due to their size and location, these institutions were unable to provide the individualized treatment vital to the child's successful reintegration into his home community. In place of institutions, the Department is offering children a wide range of community-based treatment options, staffed and managed by trained personnel and professionals. After thorough medical, dental, and psychological evaluations, most children will be placed in or near their communities in a program tailored to meet their specific needs—educationally, vocationally, and psychologically.

Children in a detention status, that is, children awaiting trial, have in the past been housed in large institutions. These children will now undergo a radically different experience prior to trial:

J. B.'s family is in a state of chaos. Since the time of his parents' divorce, his father's whereabouts have been unknown. J.'s mother is unable to work since there are five other children at home. She supports the family on payments through Aid to Families with Dependent Children (A.F.D.C.). J.'s offense is "use of a motor vehicle without authority", i.e., stealing a car. Since the time of the divorce, his performance in school has been consistently poor.

The court recommended that J. be held in detention until the time of his trial. J. is residing at a new shelter care facility called Sons of Mary in Framingham. Eleven other D.Y.S. children reside at the facility; six of the eleven are enrolled in a nearby school. During the one to two-week period until his trial, J. is involved in group therapy and intensive individual counselling. With the help of his counselor, he is deciding what kind of educational or vocational program would best suit him. He is exploring his feelings about his family, his behavior, and himself. During this time, J.'s counselors at Sons of Mary and a D.Y.S. "Court Liaison Officer" are working with the court and local agencies to locate appropriate alternatives to commitment for him. By the time J. goes to court, his court liaison officer will be able to recommend several options the court may utilize rather than committing J. to the Department.

The Court Liaison Officer accompanies the child to court. He is thoroughly familiar with the juvenile court system and with the child's problems and needs. While the child was in detention, the Court Liaison Officer researched the services available to the child in his community. If the child's home situation precludes his return, the Officer will work with the Department to locate a suitable placement either in a special school or in an approved foster home. If the child's home is suitable for his return, the Court Liaison Officer may recommend that he be sent home, provided he receives the services he requires. The Officer then assumes responsibility for linking up the child with the services.

The Commonwealth's juvenile courts have proven amenable to this option and have given a great deal of cooperation to the program. It is expected that The Court Liaison Program will obviate the need for judges to commit children to the Department when there seem to be no other alternatives open.

A detention program for girls similar to Sons of Mary, but based in Boston, is the Interfaith Shelter Care Facility for girls. At Interfaith, counselors are available to the residents on a 24-hour a day basis. Psychiatric consultation will be provided by the Douglas A. Thorne Clinic for Children. While in residence, the girls receive educational tutoring and vocational testing. The Department assigns each child a Youth Advocate Worker, someone whose full-time responsibility is counselling and locating any needed services for each child. Girls from the area south of Boston are placed in a similar program run by the Brockton Y.M.C.A. The Westfield Detention Center, The Worcester County Detention Center, The North Shore Shelter Care Facility, and Camp Dorchester will also treat detention children from their own regions. By operating a regional state-wide detention system, the Department hopes to alleviate the problem of overcrowding which has hampered previous detention programs. Approximately 100 detention children will be placed in foster homes approved by the Department during the time before their trial.

Children in detention status at Camp Dorchester, owned by the Greater Boston Y.M.C.A. and located in the Blue Hills, recently enjoyed a new experience. The children expressed a strong desire to attend a Boston Bruins game. Since Camp Dorchester is five miles away from the nearest bus line into Boston, the children and their counselors decided to hike to the station and home again after the game. Not one child proved to be a discipline problem and the group thoroughly enjoyed themselves.

During the past year, the Department has run a Parole Volunteer Program for children on parole in the Boston area. The program has proven so successful that it is presently being expanded into all regions of the state. A Parole Volunteer will be able to give a great deal of assistance to R.G.:

R. G.'s parents were recently divorced; R. becomes tearful whenever the subject is mentioned. His deviant behavior seems to have been an angry reaction to the breakup of his parents and the resulting confusion in his family. R. wants to go home to his family and enroll in a trade school for auto mechanics. If his return home is to be successful, R. will need a male figure who can offer him strong support and guidance. The Department is assigning R. to the care of a Volunteer Parole Aide. Parole Volunteers, located throughout the state, have been trained by Department clinicians and have a thorough understanding of the child's specific emotional needs. An intensive one-to-one therapeutic relationship between R. and his Aide began when R. was committed to the Department. R.'s Parole Aide will be in continual contact with him. If R. should need any service, for example, a remedial course for school, a visit to the doctor or dentist or psychiatric consultation, his Parole Volunteer will locate the service in his community and accompany him. The Parole Volunteer will help R.'s family by locating any services they might need. R. and his Aide will participate in group sessions with other children and their Volunteers weekly.

Children who need to come to grips with their problems in a stable, supportive, environment or who cannot return to disordered, chaotic homes may become residents at any one of 20 group homes located around the state. Ten to twelve children reside in each home, located close to their communities. The group home is a therapeutic community designed to help the child understand his behavior and the motivations which prompt it through intensive therapy conducted in an atmosphere of trust and mutual support. Children may reside in the group home for three or four months, or longer if necessary. While in residence, children receive group and individual counselling, psychiatric consultation, educational testing, and vocational guidance. Those children who wish may be enrolled in the local school; some divide their time between school and work; others receive in-house educational services. Both staff and children participate in the upkeep of the home.

M. W. is a fifteen-year-old boy who was committed to the Department as a "stubborn child". His parents are divorced. His father is believed to be residing in the mid-West, although his exact whereabouts are unknown. His mother, who has made an appearance in court on a narcotics charge, supports herself by prostitution. M. was a neglected child; before commitment, he had not been to a doctor or dentist in years, his nutrition was sporadic and poor, and his school attendance was limited. In spite of his above average I.Q., M. was not able to function in school. Most probably, M. was committed to the Department in order to remove him from his home situation, since several other agencies had tried to place him without much success. He has been committed to the Department several times in the past.

M. has been placed near his home in a group home called Genesis II in Springfield. Six other D.Y.S. boys reside there at the present time. A married couple, both of whom have extensive experience working with children, act as "house parents," and two other counselors are in residence. M. and the other boys work with the staff in maintaining the house. A "chore wheel" is rotated weekly to assign each child a task that is his responsibility.

During the day, M. attends the school operated by Genesis II along with a few of his housefellows. He is receiving remedial education to bring him up to his grade level in school. Shortly, M. hopes to be able to enroll in the nearby public school. Two of the boys have chosen to attend the Genesis II school half-time while spending their mornings as apprentices to a local printer and a local mechanic.

In the evening, the staff and the children meet for a group therapy session where the youths discuss their problems and feelings. A local psychologist is in attendance and is available to do psychological testing. Whenever a child needs to discuss a problem, he meets with one of the resident counselors. Medical emergencies are handled by a local physician and dentist. After the evening meeting, some of the boys go bowling, others learn leatherwork from a local craftsman, and some make use of recreation facilities in the Y.M.C.A.

During the summer, all the boys are engaged in some kind of work. Some help the Springfield Action Commission raking leaves or mowing lawns. Others shift their apprentice work to a full-time basis. The group takes field trips on weekends and attends local movies.

Those children who need to remain in the group home for a longer period may stay on if the staff and the Department think it advisable. For those boys who can return home, a Parole Volunteer is assigned to make sure the child and his family can receive any needed services. Twenty group homes located throughout the Commonwealth will be able to treat 800 or more children each year.

Not all the children who are committed to the Department can be placed in the community. The Department estimates that 5-10% of its children have severe emotional problems that require intensive treatment in secure settings. Almost every one of these children has a long history of abuse, neglect, and often violent rejection by his family. Some of these children are highly suicidal, most suffer massive depression, and almost all are behavior problems. For this group, psychotherapy is essential and full-time supervision a necessity. Wings of the Judge J. J. Connelly Youth Center and The Worcester Detention Center are being redesigned to meet this need. These long-term intensive treatment units are to be staffed by two psychiatric teams from the Human Resources Institute, Inc., a private professional psychiatric corporation which will emphasize the establishment of a therapeutic community milieu within both units.

Homeward Bound, a D.Y.S. program that has proven highly successful over the past few years in dealing with first commitment children, is presently undergoing large scale expansion and a shift in program emphasis. Two Homeward Bound programs, located in East Brewster and Middlefield, are beginning to treat court referred rather than committed children. Further, the Middlefield program is now opened to girls as well as boys.

Homeward Bound is modelled on the international Outward Bound Program which stresses physical and emotional fitness through a strenuous outdoor physical fitness component where children learn to exceed their own expectations and bolster their self-confidence, and a "solo" component, where the youth goes into the surrounding woods armed with his new survival skills. The program is particularly well-suited for older adolescents whose problems at home and difficulties at school have reinforced a sense of personal inadequacy. Small group meetings and counselling sessions during the first four weeks of the program help the youths to deal with conflicting emotions and self-doubts.

Specialized placements are now being utilized by the Department for children with problems the Department needs outside help to serve:

C.T. is eighteen years old, unmarried, and pregnant. She wants very much to keep her baby. C.'s mother was divorced and remarried, and both her mother and step-father are employed. Her counselor feels that C. should return home after the baby is born and that C. will need help in locating a part-time job and reliable baby-sitters.

C. is residing at Marillac Manor where she is receiving good prenatal treatment and education in infant and child care. She is also receiving counselling services to help her deal with her problems. After the baby is born, a Parole Officer will be in close contact with C. and help her get established in her home community.

R. L. is a seventeen-year-old youth who was committed to the Department as a runaway. R. is mentally retarded, cerebral palsied, and has a deformed arm and leg. He suffers from intense depression and has masochistic tendencies. R. has been placed at Rockland School for Exceptional Children where he receives expert psychological treatment and special education classes.

T. B., age 17, has a drug problem. T.'s mother has had four known marriages, although there have been many other men who have lived with her and her four children. T.'s father, who has a lengthy criminal record, refuses to recognize T. as his child. T. has lived in more than 14 foster homes and has had contact with several social welfare agencies. T. has been in trouble with the law since he was 13.

T. has been placed in a program called Adolescent Counselling in Drugs (ACID) in Malden. The program is geared to treat children ages 17 and under who reflect drug problems as well as a whole array of developmental problems. The objective of the program is to help each youth understand himself and his present life patterns so he can modify his behavior and self-image. ACID is a program which is closely tied to the services offered by the Malden Community. T. will reside at ACID anywhere from three to six months, although he will remain in the program on an outpatient basis after he leaves for a foster home. Other drug treatment programs utilized by the Department will include Liberty Street Associates on the North Shore, The New Perspectives School in Brookline, Hyde Park House, Spectrum House, now at the Industrial School for Boys at Shirley, Transition House at Topsfield, Mass Transition in Roslindale, and others.

The Department of Youth Services is deeply involved in helping children who, due to personal problems of any nature, have gotten into trouble with the law. The Department is providing each child with a specific treatment plan geared to his own personal needs. Because each child's needs are different, a wide array of treatment modalities needs to be made available to the Department's children.

It is the belief of the Department that, whenever possible, a child should be treated within his own community. Local courts, police, and school systems have expressed their willingness to help these youths reenter community life. The Department will be responsible for insuring that these children receive all the help they need both during the time they are under the Department's direct care and after they leave. Thorough evaluations, creative programs, sophisticated treatment and therapy, and community support are the means vital to achieving rehabilitation for children who have so many needs and have in the past received so little constructive help.

(B) PERSPECTIVE ON HISTORY AND STRATEGY FOR PHASING OUT STATE JUVENILE INSTITUTIONS

The Department's objective to close its large training schools has to be seen in the perspective of a national revolution in treatment of not only delinquents but the insane, criminal, orphaned and poor. We no longer are able or willing to treat or punish these groups of people as inmates of incarcerating institutions. Reformatories and training schools (or houses of refuge) are going the way of almshouse or orphan asylums. Viewed within an historical perspective on the institutionalization of deviant or dependent people, back to the early 19th century, the Department of Youth Services and the Commonwealth of Massachusetts are merely one decade ahead of the rest of the nation in the degree to which we are moving away from the incarcerative mode of coping with juvenile problems.[*]

Increasing reliance on probation and parole, to decrease the distance between juvenile and community, is a national trend designed to reduce reliance upon incarceration of both children and adults. However, in our judgement, the proponents of deinstitutionalization may promise and expect too much in terms of effecting "cures" for anti-social behavior in community-based programs. It is important to explicitly state what we know and what we do not know.

We know that:

- incarceration in training schools (or other correctional institutions) is inhumane by current standards, destructive and humiliating of inmates even under the best of circumstances, educates youth in the ways of crime and anti-social behavior, is incredibly expensive as either a correctional or rehabilitative method, and that these infantalizing, corrupting and expensive characteristics are inherent in institutions and not susceptible to reform.
- juvenile corrections institutions, in Massachusetts or elsewhere, do not: rehabilitate anybody, produce lower rates of crime, or decrease chronic recidivism.
- community-based programs (probation, parole, group homes and half-way houses, foster care, volunteers and advocates) will do no worse than the incarcerating institutions, and the price to society—in human and financial terms—is bound to be much lower.

We do not know that:

- community based programs for prevention and treatment of juvenile delinquency will solve the current problems of youth crime or related family breakdown, or reduce the number of juveniles appearing in courts.
- the adjudication and commitment rate of juveniles in the State will be lowered since it is dependent on many factors which have little to do with previous incarceration of the youth, such as location of the court, judge in session, social and economic status of family, adequacy of legal counsel, alternatives available, etc.

In sum, the Department's strategy for deinstitutionalization is based on some simple and realizable goals and not on some fanciful notions of reform, based on techniques which social science has not yet invented. The strategy is to ameliorate existing conditions in the most humane ways possible at the most economical level of financial cost, to conserve the scarce resources of the Department, State Government and the taxpayer. Included in this strategy is a number of secure intensive treatment units, as places of last resort, which hopefully will prove rehabilitative for hard core recidivists, highly disturbed, dangerous youth.

STATUS OF DYS INSTITUTIONS

The Industrial School for Boys at Shirley was closed on January 3, 1972. The population of 60 children was placed, according to individual needs, in group homes, on parole, on intensive parole with private agency casework services, and in other DYS facilities.

The Lyman Training School was closed to new intake on January 16, 1972. Most of the original population of 150 children has been placed in community programs, on parole, or at the Conference at the University of Massachusetts (see rationale below). As soon as the intensive treatment programs at Worcester and Roslindale are operational, the remaining 20 children will be moved to one of these units.

The Industrial School for Girls at Lancaster will be closed by May 1, 1972. Three remaining cottages which have developed highly successful treatment programs will be contracted out to private sources and relocated in separate communities. The rest of Lancaster will be placed through a process similar to that which was employed at the Lyman School.

As of January 2 the facility at *Oakdale* serves as the Department's new reception center, where children are medically and psychologically evaluated for placement. The 19 committed children formerly at Oakdale have been placed in a variety of home and residential settings.

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[*] See attached articles: "A State Decides to Stop 'Warehousing Kids'," *National Observer*, January 1, 1972, "Massachusetts Reforms to Doom Youth Prisons," *New York Times*, January 31, 1972.

The former *Worcester Dentention Center* and the *Judge J. J. Connelly Youth Center* in *Roslindale* are currently being reorganized to meet the needs of youth requiring intensive psychiatric treatment in a secure setting. Each facility will be able to accomodate about 20 youths. Youth in a detention status who require intensive supervision will be shifted to Roslindale.

Westfield Detention Center will continue to treat detained youth and, on a limited basis, function as the reception facility for Western Massachusetts.

RATIONALE FOR THE CONFERENCE AT THE UNIVERSITY OF MASSACHUSETTS

1. The process of assessing the placement needs and requirements of our youth is best handled in a setting which permits the youth to freely express their feelings and thoughts about themselves, their past and future, i.e. (1) a non-institutionaliz and thoughts about themselves, their past and future, i.e. (1) a non-institutionalized setting, (2) where the role of the youth is not that of an inmate, (3) where the potential placement options can be thought through and tested over time with a single concerned person, and (4) where the setting enriches the content of the decision-making process on education and achievement and invests the "turf" with positive feelings.

2. The ideal vehicle for the learning and decision-making process re return to home or placements is an educational institution, where the content of the experience is analogous to the Upward Bound program.

3. Role models are more important in the process of defining future expectations for performance among delinquent youth than any other factor and an educational institution proves intensive role model contact and experience.

4. Emptying institutions requires a holding program operated on a non-institutional basis, for the reasons stated above, which stresses one-to-one relationships between helper/advocate and youth, to individualized the process of deinstitutionalizing youth.

5. The opportunity was available to utilize the University of Massachusetts to accomplish the above objectives. If the University and its student organization, JOE, had been unavailable, the plans for phasing out Lyman and Lancaster would have been delayed, as originally scheduled for up to 2 months. In this sense, the Conference at the University of Massachusetts was opportunistic in the best sense of the term.

PROJECTED CHANGES OVER THE NEXT 6 MONTHS

Secure Intensive Care Units

Commencing immediately the secure units at Worcester Detention and Roslindale will treat dangerous and highly disturbed youth. These two units will be staffed by teams combining carefully selected Department personnel and private psychiatric and social work resources purchased from organizations such as the Human Resources Institute, Inc., based in Brookline. A third secure intensive treatment unit, using a similar staffing pattern, will be opened in the Western areas of the state by May 1, 1972. In addition, a maximum security detention unit will be established at Roslindale to handle the limited number of detained youth requiring incarceration.

Services for Children Referred by Courts

The Department is going to place an increasing emphasis on working with first and second offenders. To avoid the stigmatization of an adjudication of "delinquent", the Department will provide the courts with alternatives to adjudication on a referral basis. The first of these programs is the ForestryProgram modeled on the Outward Bound School and located on the Cape at Brewster. Each region in the state will be allocated a proportionate number of Forestry slots for boys aged 14–17 eligible to participate in the six week program. We hope to offer this same program for girls by June 30. The first class to be admitted on a referral basis will be February 5th with the next intake date set for the first week in March.

Court Liaison Program

In large measure the success of deinstitutionalization is dependent upon good communication between courts and the Department. To facilitate our ability to respond to the courts' needs, during the month of February we will be placing liaison personnel in a number of courts to help develop community remedies for children in trouble and assure the most suitable care available for those youth placed in the custody of the DYS.

Detained Youth Advocate Program

The Detained Youth Advocate Program, to be implemented March 1, will employ 100 Youth Advocates from seven major urban areas of Massachusetts to provide intensive counselling and referral services to one or two detained youths living in their homes. Specifically, the objective of the Youth Advocate would be to spend the seven to ten days between arraignment and adjudication working with the adolescent, talking with the family, and exploring as many community resources as are available. The Youth Advocate, with the assistance of probation, could then make recommendations to the court, which if accepted could be put into effect immediately. In this way the arraigned youth would avoid commitment to the Department of Youth Services facilities as well as not being subject to the maximum security detention unit.

Parole Volunteer Program

This program began a year ago with carefully selected and trained volunteers assigned initially to positions as supportive friendship counsellors or tutor-advocates in academic, occupational, vocational, or social skills. The paramount goal of the Parole Volunteer Program is to develop an effective after-care treatment plan for every parolee in the Department through the use of volunteer services. The operation of the program is currently limited to the Boston and Worcester areas with 110 volunteers working with an equal number of children, spending an average of two evenings and a weekend day with each child. Plans call for expansion of this service to other urban regions, starting with Springfield, Lynn, Fall River and New Bedford.

Youth Advocate Program

The Department's unique Youth Advocate Program funded by the President's Emergency Employment Act (P.L. 50-42) and channeled through the Department of Manpower—Office of Human Services, currently employs 35 Youth Advocate Workers from seven major urban areas of Massachusetts to provide intensive counselling and referral for one to three youths in the home of the Youth Advocate Worker. During the youth's stay with the Youth Advocate Worker, he may enroll at a local public school or any specialized or vocational school in the community and may take part in community-sponsored programs (e.g. YMCA, drug programs, Big Brother Organizations, etc.). The Youth Advocate Worker accompanies the youth on field trips and participates with him in recreational activities. In addition, the Youth Advocate Worker will serve as a referral agent by making psychiatric counselling, medical care, family counselling, and school counselling available to the youth, as needed.

Expanded Use of Existing State-funded Private Group Homes

As an alternative program for those children not requiring secure intensive care, the Department will double its purchase of private group home care. Two years ago fewer than 40 children in the Department's custody benefitted from these group home and half way house programs. By last July, the figure rose to 150 children and today 200 children are in group residential settings.

New Federally Funded Group Homes

Through Law Enforcement Assistance Administration (LEAA) funding, the Department is contracting for a minimum of 17 group homes to house at least 200 youth at one time and at least 600 youth annually. In February, at least 7 of these group homes are expected to be operational, another 4 in April and 6 more in May.

STAFF OPTIONS

Employees at the DYS institutions have been presented with a wide range of positions open in the new programs. Employees will make written request for reassignment based upon their assessment of their skills and employment goals. The following positions are open in all seven regions:

Facility/area:	*Positions*
Group Homes	Counsellors.
Reception and Detention Centers.	Teacher-counsellors, group workers, clerks/secretaries, transportation workers, cooks/dietitians, physical education instructors and aides.
Mobile Maintenance Team	Carpenters, painters, electricians, plumbers, handymen, truck drivers.
Homeward Bound-Forestry Camps.	Brigade leaders, counsellors, cooks/dietary personnel.
Regional Offices (7)	Transportation employees, clerks.
Communities	Regional community workers, placement workers, parole supervisors, parole volunteer coordinators, foster home specialists, parole agents, community representatives, and foster parents.

RELEVANT BACKGROUND INFORMATION

In 1971, the courts of the Commonwealth committed or recommitted almost 1,100 youth to the Department, 968 of whom, or 88%, were placed by the Department in the Industrial School for Boys at Shirley, the Lyman Training School, and the Industrial School for Girls at Lancaster. The remainder went from the courts to other DYS facilities: Worcester, Westfield, Roslindale, the Forestry Camp at Brewster, Oakdale, Topsfield, and Hyde Park House. The average cost per youth of institutional custody in 1971 was $11,641.* About 50% of the youth committed to the Department in 1971 resided in 10 cities, with the largest number from Boston, two-thirds of whom resided in the Dorchester or Roxbury sections, as indicated below in rank order:

Cities	Residences of committed youth			Number of paroled youth
	Boys	Girls	Total	
Boston:				
Dorchester	85	22	107	65
Roxbury	57	4	61	70
Remainder	73	11	84	85
Springfield	51	11	62	80
Worcester	39	12	51	110
Lynn	31	7	38	25
Somerville	32	2	34	25
New Bedford	33	0	33	38
Lowell	25	5	30	30
Fall River	20	4	24	40
Cambridge	13	2	15	30
Quincy	13	1	14	14
Total	472	81	553	612

At the same time, as indicated above, on any given day in 1971 in each of these 10 cities there would be approximately 612 paroled youth living at home, about half of the paroled youth under the Department's supervision. Unfortunately, these paroled youth were recidivating at a rate of close to 80% within a year of parole. Thus it can be said that in effect most youth on parole were only temporarily free pending parole violation, and recommitment to DYS training schools.

Almost 60% of these committed and paroled youth were from AFDC families and almost 90% of their families qualified for some form of welfare assistance. About 60% of the girls and boys, for example, were from broken homes characterized in most cases by alcoholism problems. At least 25% were living with their mothers only.

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* Source: June 1971 Financial Report from each institution. This report gives the average number of youths fed per day for the fiscal year.

The keys to closing the large training schools in early 1972 were: (1) *flexible funds* for the purchase of residential care and a variety of services for at least 1200 committed youth in 1972; (2) *flexible funds* to purchase advocacy and counselling services for most detained youth awaiting trail, aimed at developing for them alternatives to adjudication and commitment to the Department; (3) *flexible funds* to purchase specialized care under close supervision for 15% of the committed youth or about 100 annually; (4) the capability to reassign Institutional staff to positions in regional and community based operations and programs; (5) the prospect of cooperation from Administration and Finance and the Legislature in shifting budgetary resources from institutions (other than those necessary for maintenance and upkeep) to regional operations.

The supplementary appropriation of $1,000,000 for the Department's purchase of service account was the most significant resource in meeting requirements 1–3 above for flexible funds. In addition, the Department has received the first $325,000 out of at least $1.85 million of Federal LEAA funds to purchase residential alternatives and specialized services for committed and detained youth over the next 12 months. In the second half of fiscal 1972, as part of the process of closing down its training schools, the Department will spend flexible money from the following sources:

Sources of program funds, January 1–June 30, 1972

1. Purchase of Care (State):	
Regular Budget	$480, 000
Supplementary Budget	1, 000, 000
Subtotal	1, 480, 000
2. LEAA Funds:	
Group Homes	605, 000
Homeward Bound (Brewster)	116, 000
Detained Youth Advocates	60, 000
Regionalization of Administration and Services	215, 000
Parole Volunteers	40, 000
Subtotal	1, 036, 000
Total	2, 516, 000

Projected Targets for Placements and Services in 1972

In order to provide adequate community based residential and nonresidential services for committed and paroled youth, the Department projects the following program targets for this year:

	Capacity at any one time	Annual	For youth Who Are—	
			committed	Paroled
1. Residential treatment:				
(a) Group homes	400	1,000	1,000	
(b) Home Placements and services:				
(1) Foster home placements	150	200	200	
(2) Youth advocates (parole)	120	360		360
(3) Intensive casework services	50	100		100
(4) Volunteers	300	600		600
Subtotal	620	1, 260	1, 200	1, 060
2. Specialized programs:				
(a) Homeward bound	50	[1] 600	[1] 300	
(b) Secure intensive care for disturbed/dangerous youth	50	100	100	
Subtotal	100	700	400	
Total [2]	720	1, 960	1, 600	1, 060

[1] Approximately 300 youth annually will be court-referred.

[2] Above does not include placement and advocacy services for detained youth. Postparolee services (followup after release) not included in the above.

Specifically, the State and Federal funds currently are being used to purchase the following kinds of community based alternatives to institutionalization:

I. Group residential care programs:	
1. Existing purchase of residential care from private group homes, therapeutic and educational facilities:	
a. Number of private residential placement facilities (See Attachment A)	48
b. Yearly cost per capita	$7, 000. 00
c. Number of DYS children placed as of Jan. 14, 1972	175
d. Additional number to be placed by Feb. 28, 1972	25
e. Total number of youth placed annually	400
2. New group homes being established through Federal funds under Law Enforcement Assistance Administration (LEAA):	
a. *Total number of homes*	17
b. Total awarded grants by Jan. 26, 1972	10
c. Number established by February 15, 1972	2–3
d. Capacity at any time	200
e. Total yearly capacity	600
f. Total *initial* per capita yearly cost	[1] $10, 229. 00
g. Number of proposals received (See Attachment B)	46
h. Proposals accepted: New England Home for Little Wanderers, Dorchester; Acid, Inc., Malden; Hyde Park House, Newton; DARE, Bourne-Wareham; SHARE, Lowell; Walker Home, Newton-Cambridge; Roxbury Medical-Technical Institute, Boston; Groupways, Inc., Boston; Libra, Inc., Cambridge; St. Ann's Home, Methuen	10
i. Proposed locations for remaining LEAA funded homes (2 Springfield area, 2 Worcester/Gardner/Fitchburg area, 1 Middleboro area, 1 Lynn, 1 Dorchester/Roxbury area)	7
II. Foster care placements:	
1. Funded by Emergency Employment Act (EEA)	70
2. Funded by State purchase of care budget	75
III. Purchase of intensive casework services from private agencies for children on parole:	
a. Number of DYS children	90
b. Cost per child per week	$25. 00
c. Agencies currently involved: New Bedford Child and Family Services, North Shore Catholic Charities, Boston Catholic Charities, Cambridge-Somerville Catholic Charities	4

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[1] $9,535 after the first year, including an annual per capita cost of $1,166 for DYS staff allocated to each group home.

(C) BRIEF DESCRIPTION OF FUNDED PROPOSALS TO ESTABLISH COMMUNITY BASED TREATMENT UNIT

DARE—Region 7

Coed Program—5 boys 5 girls (13 to 17 years old).

Family counselling with youth and family to develop a home environment and gain support to be constructive in the community

Advocacy techniques will be used in order to create the best opportunities.

Individual and group counselling.

Recreation cultural and educational enrichment programs.

Aid to other community agencies to develop needed human service programs to meet the needs of youngsters.

Continued supportive relationship will be maintained 4 months after discharge.

Acid—Region 4

Boys Program—12 Boys (17 years and younger).

Three stage program starting with:

(*a*) Highly structured, closely supervised environment as he begins to exhibit his ability to accept responsibility for himself and set his own limits. He will be allowed privileges and at that time he will be given increasing opportunities to exercise his own decision making ability. Freedom extended to the youth is built on a privilege system which he earns by fulfilling demands of residence, responding he earns by fulfilling demands of residence, responding to therapy and becoming a meaningful member of the therapeutic environment. More freedom is accorded, without staff observation, including weekends home, as the youth illustrates responsible decisions concerning his own behavior as well as that of his peers.

(*b*) The second phase is to assimilate the youngster back into the community by involving him in an educational and/or vocational program as well as initiating family therapy groups. This is establishing a "State of Readiness" in the family for the child to return to the home when discharged.

(*c*) Eventually his behavior, as seen in total ie. ability to handle himself in therapy groups, with his family and in school or on the job, will determine his readiness to return home or be placed in a long term treatment program. The individual understands that he determines his own behavior, is capable of establishing his own limit-setting mechanisms and ultimately this determines his date of discharge. ACID staff maintains an on going relationship for at least 4 months after the youngster leaves the program. The supportive aftercare services will be arranged according to individual needs.

Groupways—Region 6

Boys Program—12 Boys (15 to 21 years).

This program is unique in that Groupways has four facilities in the same neighborhood all of which embrace both long-term and short-term placements, youth desiring to remain with the program at the conclusion of their short term stay may have the opportunity of doing so. This mixing of both committed and non-committed youth has the advantage providing positive peer models beginning the first day of residence. Groupways, having been established in 1963 has been working with local vocational, educational and recreational programs that the youngsters will participate in while living there. Family therapy will be continued after the youngster leaves the program to aid in the transition from the group home environment to the home.

Everett House, New England Home for Little Wanderers—Region 6

Girls Program—12 girls (14 to 16 years).

The goal of this program is to help girls in their pursuit of maturity and responsible independence. Generally the girls behavior patterns and methods of coping have been counter productive to date. Realizing this, it is necessary to help the girls develop alternate approaches of coping that capitalize on their strengths and those of their families in a way that establishes a pyramid of positive accomplishments. The girls are aided in identifying available alternatives and developing positive decision making abilities. In this way, they slowly learn to be accountable to themselves and others. The program includes extensive educational, vocational and family adjustment programing.

Libra—Region 3

Boys Program—12 boys (12 to 16 years).

The youngsters are seen as full scale participants in the activities and the decision-making of the home; the initial group will participate in drawing up the operating roles for the house. Each youth will be involved in the total planning for his stay at LIBRA. The house will operate on a progressive scale of priviledges earned by illustrating the ability to accept responsibility and act in a constructive manner. Staff will act as counselor advocates for the youngsters while working out their problems with their families, school systems, and other community resources. Youngsters will be contacted on a regular basis for as long as one year after discharge to assure smooth transition from the home, back to the community.

Hyde Park House—Region 5

Boys Program—12 Boys (12 to 16 Years).

This program is initiated by an interview with the boy's family and at this time a general treatment program would be outlined for both the youngster and his family. For the youngster this would be the residence and for the family it would involve weekly parent groups, family therapy or individual therapy. Recognizing the strengths and weaknesses of the boy ane his relations with his family and chosen peer group, the program can be designed to help the boy learn positive decision making. Each resident will undergo evaluation of his educational needs, including establishing the achievement level as well as the cognitive development level. Youngsters will begin with limited goal settings which will include writing weekly self evaluations which are matched with staff attitude reports. It is in this way priorities for programming are established.

The youngsters are offered non-delinquent patterns of behavior and educational programs which will help them on discharge.

Roxbury Medical Technical Institute—Region 6

Boys Program—12 Boys (6 to 18 Years).

Experimental and innovative approaches to presenting academic material will be explored in depth. There will be a strong emphasis on interweaving all aspects of educational, vocational, recreational and counselling programs for youth. Debating, creative writing, club activities, special interest groups and keeping journals will be some of the tools used in the educational component in order that the youth can more easily identify the immediate relevancy of learning in his day to day life. Efforts are being made to build the academic and vocational programs with materials which would enhance minority group ethnic identity and pride. When a youngster leaves the program, he will be encouraged to continue taking part in the programs. The parent involvement, too, will be maintained as the location is central.

Walker Home—Region 3

Boys Program—12 Boys (7 to 13 Years).

Mainly for young boys with severe school adjustment problems. Walker School has developed an excellent program of teaching appropriate school behavior which helps the youngster cope with that system which he must deal with the most hours per day. By providing the child with a repertoire of socially appropriate behavioral responses early in life, he will be much better able to cope with those aspects of school life which he acted out against in the past. The child is taught early the importance of recognizing emotions and expressing them in a constructive manner. Constant interaction with the boy's family will be maintained throughout the boy's stay at the group home to avoid a difficult transition upon return to the family. The parents will be contacted on a regular basis after discharge to supply support to the total family unit as needed.

St. Ann's Home—Region 4

Boys Program—12 Boys (8–14 Years).

Acting out character disorder boys, many of whom have been identified as emotionally disturbed.

The group home will operate on the principle that all behavior, including the most flagrant sort of acting out is learned and the dysfunctional learing pattern must be interrupted and substituted with a more constructive learning experience. The members of the home will be inolved in rule making, household organization and will be responsible primarily to the group as to their behavior and its consequences. A variety of models for the group to learn from and identify with will be provided by the staff. Educational support programs will be provided to help the youngster return to school at the level of his age group. At least once a week the child will have a family meeting with either one or more members of his family in order to maintain and strengthen family ties while in the group home.

Share—Region 3

Boys Program—12 Boys (15 to 17 Years).

Seen as necessary for admission to this group home is a willingness on the part of the family to take part in the family counselling component of the program at regular intervals. An adult-structured environment is seen as a need. However, the adolescent in-put will be solicited at specific levels of decision making and growth. The goal is to provide an environment with clearly defined roles and expectations. Orientation in the program includes defining the levels of accomplishment which must be passed through for discharge. Advancement from one level to the next is a house member and staff decision made in one of the daily meetings. The group makes recommendations, and if the youth is unable to maintain the stated criteria of behavior, he is put back a level for a period of time until he exhibits the ability to accept additional responsibility required until he is able to function successfully in the community with his family and job or school.

(D) STATE OF MASSACHUSETTS ACT OF 1969 CHAPTER 838 ESTABLISHING THE DEPARTMENT OF YOUTH SERVICES

Chapter 838—Acts of 1969

Provides:

SECTION 65. The youth service board, the division of youth service and the advisory committee on service to youth are hereby abolished, and the offices of the members of the youth service board, and director, first deputy director for administrative services, second deputy director for field services, and third deputy director for institutional services of the division of youth service are hereby terminated. All powers and duties exercised by said board and division are hereby transferred to the department of youth services established under section one of chapter eighteen A of the General Laws, as appearing in section one of this act; all powers and duties exercised by the advisory committee on service to youth are hereby transferred to the advisory committee in the department of youth service established under section nine of said chapter eighteen A; and all powers and duties of said offices of chairman, member, director and deputy director are hereby transferred to the commissioner of youth services appointed under the provisions of said chapter eighteen A or to other officers and employees of said department in accordance with the provisions of said chapter eighteen A.

SECTION 66. All officers and employees of the division of youth service who immediately prior to the effective date of this act hold positions classified under chapter thirty-one of the General Laws, or have tenure in their positions by reason of sections nine A, nine B and nine D of chapter thirty of the General Laws, shall continue to be employees of the department of youth services without impairment of civil service status, seniority, retirement and other employment rights, and without interruption of service within the meaning of said chapter thirty-one or said section nine A, nine B or nine D, and without reduction in compensation and salary grade, notwithstanding any change in title or duties made under this act. All officers and employees of said division who immediately prior to said effective date do not hold positions classified under said chapter thirty-one, or do not have tenure in their positions by reason of said section nine A, nine B or nine D, shall continue to be employed in the department of youth services under this act without impairment of seniority, retirement and other rights, and without interruption of service within the meaning of said section nine A, nine B or nine D, and said chapter thirty-one, and without reduction in compensation and salary grade.

Upon the effective date of this act the status of any employee of any board, division, bureau, section or other administrative unit under the division of youth service, except those persons and officers appointed by the governor, or the status of any employee of the advisory committee on service to youth, including the position of executive secretary to the advisory committee on service to youth, who immediately prior thereto did not have tenure under section nine A of chapter thirty or chapter thirty-one of the General Laws shall be transferred to the department of youth services, established by section one of chapter eighteen A of the General Laws, inserted by section one of this act. Said incumbent executive secretary to the advisory committee on service to youth in order to provide continuity for the newly created advisory committee in the department of youth services shall continue to serve and shall fill the position of full time executive secretary to the advisory committee in the department of youth services.

SECTION 67. The term of the commissioner of the department of youth services first appointed by the governor under the provisions of section one of chapter eighteen A of the General Laws, inserted by section one of this act, shall, notwithstanding the provisions of said section one, terminate on the second day of January, nineteen hundred and seventy-five.

SECTION 68. The commissioner of youth services, in consultation with the advisory committee, shall study and review the effectiveness of the administrative structure of the department of youth services as provided in sections one through nine, inclusive, of chapter eighteen A of the General Laws, inserted by section one of this act, and within one year of the effective date hereof shall report to the governor and the general court the results of such study and review and his recommendations, if any, together with drafts of legislation necessary to carry such recommendations into effect.

SECTION 69. The terms of the eight members of the advisory committee in the department of youth services first appointed by the governor shall be as follows: two members shall be appointed for terms of one year each; three members for terms of two years each; and three members for terms of three years each.

SECTION 70. All books, papers, records and documents in the custody of or maintained for the use of any board, division, committee or office abolished by this act are hereby transferred to the custody of the department of youth services. All petitions, applications, hearings and other proceedings duly pending before and all prosecutions and legal and other proceedings duly begun by or against such board, division, committee or office, abolished by this act or before or by any member, officer or employee thereof, shall continue unabated and remain in full force and effect notwithstanding passage of this act, and may be completed before or by the department of youth services. All duly existing contracts, leases and obligations of any board, division, committee or office abolished by this act shall be performed by the department of youth services or by an administrative unit, officer or employee thereof acting under authority of law. All rules and regulations adopted by the youth service board and division of youth service abolished by this act shall remain in effect as rules and regulations of the department of youth services until amended or repealed by said department. This act shall not affect any renewal provisions or option to renew contained in any such lease in existence on the effective date of this act, all of which on the effective date of this act shall be transferred to and thereafter may be exercised by the department of youth services. All property held in trust by any board, division, committee or office abolished by this act, or by members thereof, shall continue to be held in trust, and be administered in accordance with the terms of such trust, by the department of youth services or, if such department shall decline such trust, by trustees appointed by any court of competent jurisdiction upon application of nay interested person for such appointment or for instructions in connection therewith.

SECTION 71. All unexpended balances of moneys heretofore appropriated for the youth service board and the division of youth service shall be available for expenditures by the department of youth services on the effective date of this act.

SECTION 72. The provisions of this act are severable and if any provision shall be held unconstitutional by any court of competent jurisdiction, the decisions of such court shall not affect or impair any of the remaining provisions.

SECTION 73. Physicians and registered nurses permitted by law to treat inmates at any state institution shall be allowed to treat youths committed to the department of youth services in cases of emergency.

SECTION 74. This act shall take effect in October first, nineteen hundred and sixty-nine, or upon the qualification of the commissioner of youth services appointed under the provisions of section one of chapter 18A, of the General Laws, inserted by section one of this act, whichever is the later.

Chapter 6

SECTION 17. (Amended by Ch. 859, Acts of 1969). Certain officers to serve under governor and council. The army commission, the art commission, the executive office for administration and finance, the commissioner of veterans' services, the commissioners on uniform state laws, the public bequest commission, the state ballot law commission, the board of trustees of the Soldiers' Home in Massachusetts, the board of trustees of the Soldiers' Home in Holyoke, the milk regulation board, the alcoholic beverages control commission, the trustees of the state library, the state racing commission, the Metropolitan area planning council, the Port of Boston commission, the Massachusetts commission against discrimination, the state airport management board, weather amendment board, commission on aging, the boxers' fund board, finance advisory board, medical, dental and nursing scholarship board, retirement law commission, the Massachusetts aeronautics commission, the obscene literature control commission, the mobile homes commission, the consumers' council, the municipal police training council, the Massachusetts rehabilitation commission, the service corps commission, the World War II Memorial commission, health and welfare commission, advisory council on home and family, state council on juvenile behavior, and the commission on employment of the handicapped shall serve under the governor and council and shall be subject to such supervision as the governor and council deem necessary and proper.

SECTIONS 65 to 67. Repealed, St. 838, Acts of 1969.
SECTION 68. Repealed, St. 605, Acts of 1952.
SECTIONS 69 to 69B. Repealed, St. 838, Acts of 1969.

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SECTION 122. (Amended by St. 838, Acts of 1969). *Service Corps Advisory Council.*—There shall be a service corps advisory council, hereinafter called the council, consisting of ten members who shall be appointed by the governor for terms of two years each, and the commissioners of public welfare, mental health, correction, probation, public health, natural resources, education, labor and industries, rehabilitation, and youth services and the chairman of the parole board, or their authorized representatives, and the director of the service corps, as members ex officio. The director of the service corps shall serve as chairman of the council. The council shall meet at least twice a year upon call of the chairman and shall meet at any time upon the call of the governor. Its members shall receive no compensation for their services on the committee but shall receive their expenses necessarily incurred in rendering such service. The council shall study social needs in the commonwealth in areas where services may be rendered by the service corps, shall evaluate programs and projects of the corps and shall make recommendations based on its findings to the commission.

* * * * * * *

Chapter 859, Acts of 1969, which establishes juvenile courts in Worcester and Springfield, includes the following:

SECTION 32B. Said chapter 6 is hereby further amended by adding the following three sections:

SECTION 159. *State council on juvenile behavior.*—There shall be a state council on juvenile behavior in this section and in section one hundred and sixty called the council, to consist of the attorney general or his designee, the commissioner of youth services and thirteen persons to be appointed by the governor, one of said appointees shall be experienced in law enforcement in the field of juvenile delinquency, one shall be trained in child psychology, one in the education of delinquent children, one in social welfare, families and juvenile problems, one shall be a psychiatrist with a knowledge of the juvenile and adolescent mind, one shall represent the juvenile courts, one shall represent the federal office of economic opportunity as it affects juveniles and adolescents, one shall represent public child welfare agencies, one shall represent private child welfare agencies, and one shall be a member of the bar experienced in the law and court procedures relating to juvenile delinquency or juvenile behavioral problems. The governor shall designate one of the appointive members as chairman of the council. Upon the expiration of the term of an appointive member his successor shall be appointed for a term of five years. The council shall appoint an executive secretary who shall have had at least ten years' experience in juvenile delinquency work. The executive secretary shall receive a salary of sixteen thousand dollars.

SECTION 160. *Council to examine laws and procedures relating to correction and prevention of juvenile delinquency.*—The council shall from time to time examine the laws and procedures relating to the correction and prevention of juvenile delinquency and the degree of rehabilitation of juvenile offenders, with a view to advising the justices of the juvenile courts of matters affecting juvenile behavior, and to revising the laws relative to the treatment and disposition of juvenile offenders. Said council shall be provided with quarters in the state house or in the state office building, and may appoint such clerical assistants as may be necessary.

SECTION 161. *Filing of annual written report.*—The council shall annually, not later than the fourth Wednesday of April file a written report with the respective clerks of the senate and house of representatives which shall contain a reporting and analysis of the incidence and disposition of juvenile offenses during the preceding calendar year in every court in the commonwealth in which said matters are heard. Said report shall indicate the types of offenses charged together with the number of each such offenses heard in each of the several courts, with particular emphasis on providing data for the determination of the need for the establishment of additional juvenile courts and any changes in the needs of those juvenile courts already in existence.

SECTION 32C. Of the first appointed members to the state council on juvenile behavior, established by section one hundred and fifty-nine of chapter six of the General Laws, as appearing in section thirty-two B of this act, four shall be appointed for terms of three years, four for terms of four years, and five for terms of five years, as the govenor may designate. Thereafter, upon the expiration of the term of any such member, his successor shall be appointed for a term of five years, as provided in said section one hundred and fifty-nine.

SECTION 33. This act shall take effect upon its passage, so far as the appointing, commissioning and qualifying of the justices and the clerks of the courts hereby established, and probation officers are concerned; and it shall be in full force and effect, and the authority and jurisdiction of the courts hereby established and of the probation officers thereof shall begin on the first day of September in the year nineteen hundred and sixty-nine, except that the district court of Springfield, and the central district court shall retain jurisdiction of all cases of juvenile offenders under seventeen and cases of neglected, wayward or delinquent children which are pending therein on said first day of September or upon the qualification of the justice of each court, whichever is later, until final disposition thereof.

Chapter 17

Drug Addiction Rehabilitation Board

SECTION 12. Repealed, St. 889, Acts of 1969.

CHAPTER 18A

Department of Youth Services

SECTION 1. *Department of Youth Services. Commissioner.*—There shall be a department of youth services, in this chapter called the department, which shall be under the supervision and control of a commissioner of youth services, in this chapter called the commissioner. The commissioner shall be appointed by the governor, with the advice and consent of the council, for a term coterminous with that of the governor. The commissioner shall, at the time of his appointment, be qualified by having earned from an accredited institution a graduate degree in the social sciences, education, law or related fields and by having no less than seven years professional or administrative experience in work related to the problems of delinquent children and youth. He shall receive a salary of twenty-five thousand dollars, shall devote his full time during business hours to the duties of his office, shall be the executive head of the department and shall have full responsibility for the formulation and execution of all its policies and the coordination of all of its functions. He shall appoint and may remove all employees in the department. Unless otherwise provided by law, all such appointments and removals shall be made in accordance with the provisions of chapter thirty-one.

Powers and duties given to any administrative bureau, subdivision or institution of the department by any general or special law shall be exercised and discharged subject to the direction, control and supervision of the commissioner. The department may expend such sums as may be appropriated for grants to cities and towns and to other public agencies and for the purchase of services from other government departments and agencies and from private nonprofit agencies to carry out any of the program and purposes of the department. The commissioner may establish, subject to appropriation, such district offices and employ such field agents as shall be necessary or desirable to carry out the program and purposes of the department. Federal funds granted to the commonwealth to aid in the financing of any of the program and policies of the department shall be credited to a separate fund on the books of the commonwealth only for the purposes of such expenditures to be made under the direction of the commissioner. Federal funds paid as reimbursement to the commonwealth shall be deposited in the General Fund.

SECTION 2. *Coordinated program of delinquency prevention and services, etc.*—The department shall provide a comprehensive and coordinated program of delinquency prevention and services to delinquent children and youth referred or committed to the department by the courts; community services for the prevention of juvenile delinquency through its own staff, through grants-in-aid to cities, towns, and other public agencies and through purchase of services from private nonprofit agencies; and services and facilities for the study, diagnosis, care, treatment, including physical and mental health and social services, education, training and rehabilitation of all children and youth referred or committed. The department shall maintain a program of research into the causes, treatment and prevention of juvenile delinquency, including new methods of service and treatment. The department shall cooperate with other state and local agencies, both public and private, serving children and youth.

SECTION 3. *Deputy Commissioner.*—The commissioner shall appoint, with the approval of the governor, a deputy commissioner who shall not be subject to the provisions of chapter thirty-one and to whom the provisions of section nine A of chapter thirty shall not apply, but who shall possess the same qualifications required of the commissioner, except that he shall have had not less than five years experience in work related to juvenile delinquency, of which at least two shall have been as an administrator. Said deputy commissioner shall serve at the pleasure of the commissioner, and shall devote his full time during business hours to the duties of his office. He shall exercise such authority and discharge such duties of the commissioner as the commissioner may from time to time delegate to him and, in the absence of incapacity of the commissioner, or in the event of a vacancy in the office of commissioner, shall act as the commissioner until the absence or incapacity shall have terminated or the vacancy shall have been filled.

SECTION 4. *Bureaus.*—There shall be in the department the following bureaus: the bureau of clinical services; the bureau of after-care, delinquency prevention and community services; the bureau of educational services; and the bureau of institutional services. Each bureau shall be under the direction of an assistant commissioner who shall be appointed by the commissioner and who shall not be subject to the provisions of chapter thirty-one and to whom the provisions of section nine A of chapter thirty shall not apply.

SECTION 5. *Bureau of Clinical Services.*—The bureau of clinical services shall review, upon commitment or referral, the social histories and diagnostic data concerning all persons referred or committed to the department, shall conduct such further study and evaluation as may be required for clinical classification, and shall place such persons under an appropriate form of care. Said bureau shall conduct the research and planning necessary for the the continued care of each youth within the jurisdiction of the department and the development and implementation of effective individualized treatment programs for each of the delinquent children committed to the department. Said bureau shall be responsible for all case assignments, case reassignments, case dispositions, and proposals for discharge, and shall regularly review existing case assignments in the department. Said bureau shall operate the Reception-Detention Center for Girls at Boston Judge John J. Connelly Youth Center, Boston, Westfield Detention Center, Westfield and Worcester Detention Center, Worcester and subject to appropriation such other centers as may be necessary for the study and diagnosis of children's needs upon commitment or referral and for temporary shelter care in emergency cases including those children requiring secure custody.

The commissioner shall appoint an assistant commissioner for the bureau of clinical services who shall be a psychiatrist accredited by the American Board of Child Psychiatry. Said assistant commissioner shall have had at the time of his appointment a minimum of ten years experience in the field of mental health relative to children. Said assistant commissioner shall serve at the pleasure of the commissioner. He may, notwithstanding any contrary provision of law, be allowed such professional affiliations concurrent with his duties as the commissioner may approve, including the holding of a nontenure appointment at a medical school or university. Said assistant commissioner shall, with the approval of the commissioner, establish and maintain standards for all clinical and child care positions in the department and shall review the qualifications and performances of all clinical and child care personnel. The commissioner shall appoint replacement or additional clinical and child care personnel upon recommendation of said assistant commissioner together with the assistant commissioner of any other bureau requesting such personnel.

SECTION 6. *Bureau of After-care, etc.*—The bureau of after-care, delinquency prevention and community services shall be responsible for the noninstitutional programs of the department, including but not limited to foster home care, group home care, after-care services to children in their own homes, after-care investigation services unit, parole and educational counselor programs. It shall be responsible for developing alternatives to institutional care and shall provide for work with the families of children in institutions in order to facilitate their return home and their adjustment and integration into the community. It shall further be responsible for continuing consultation with other state agencies and with local community groups and agencies for the development of preventive programs, the conduct of grants-in-aid for the initiation, demonstration and development of programs and the school adjustment counselor program.

The commissioner shall appoint an assistant commissioner for the bureau of after-care, delinquency prevention and community services who shall have an earned graduate degree from an accredited institution in the social sciences, education, or related fields. Said assistant commissioner shall have had at the time of his appointment at least five years professional experience in delinquency prevention and after-care with at least two of these years having been spent in an administrative capacity in his field. Said assistant commissioner shall serve at the pleasure of the commissioner.

SECTION 7. *Bureau of Educational Services.*—The bureau of educational services shall establish and maintain programs and curricula for the educational service functions of each institution of the department and for coordinating educational services for individual youths at each stage of departmental jurisdiction. Said bureau shall establish and maintain academic and vocational education programs, curriculum development plans, teacher training programs and library services for each of the institutions of the department and each of the youth committed to the department. Said bureau shall seek out and implement federally aided educational programs. Said bureau, after consultation with the commissioner and the assistant commissioners of the other bureaus or their designees, shall develop and initiate in-service training programs for all employees in each of the institutions and facilities within the jurisdiction of the department. Approval of such training programs by the director of personnel and standardization shall be required in accordance with the provisions of section twenty-eight of chapter seven.

The commissioner shall appoint an assistant commissioner for the bureau of educational services who shall have an earned graduate degree from an accredited institution in education, the social sciences, or related fields with a specialty in the problems relating to delinquency. Said assistant commissioner shall have had at the time of his appointment at least five years professional experience in public or private secondary school, teaching in the area of delinquency prevention or teaching delinquent youth, with at least two of these years having been spent in administrative-curricula planning capacity. Said assistant commissioner shall serve at the pleasure of the commissioner. Said assistant commissioner shall, with the approval of the commissioner, establish and maintain standards for all teaching positions in the jurisdiction of the department and shall review the qualifications and performances of all teaching personnel in the department. Said assistant commissioner together with the assistant commissioner of each bureau requesting replacement and additional teaching personnel shall make recommendations to the commissioner relative to the replacement and addition of each and all teaching personnel for the institutions and facilities under the jurisdiction of said bureau.

SECTION 8. *Bureau of institutional services.*—The bureau of institutional services shall operate the Residential Treatment Unit, Oakdale, the Lyman School for Boys at Westboro, the Industrial School for Boys at Shirley, the Institute for Juvenile Guidance at South Bridgewater, the Industrial School for Girls at Lancaster and Stephen L. French Forestry Camp at East Brewster. Said bureau shall be responsible for all programs within the institutions of the department other than those programs which are primarily clinical or educational, and shall from time to time evaluate such programs to determine their effectiveness. Said bureau shall coordinate programs between institutions and also with other programs of the department to assure effective continuity in the rehabilitative process.

The commissioner shall appoint an assistant commissioner for the bureau of institutional services who shall have an earned graduate degree from an accredited institution in the social sciences, education, or related fields. Said assistant commissioner shall have had at the time of his appointment at least five years professional experience in working with delinquent children in an institutional setting, with at least two of these years having been spent in an administrative capacity. Said assistant commissioner shall serve at the pleasure of the commissioner. Said assistant commissioner shall from time to time make recommendations to the commissioner relative to the need of major alterations and renovation, expansion, relocation or replacement of existing institutions or camps and the construction of additional institution or camps.

SECTION 9. *Advisory Committee.*—There shall be in the department an advisory committee consisting of the commissioner of youth services, the commissioner of mental health, the commissioner of education, the commissioner of correction, the commissioner of rehabilitation, the chairman of the Massachusetts commission against discrimination, the executive secretary of the Massachusetts Society for the Prevention of Cruelty to Children, and the executive secretary of the Massachusetts Committee on Children and Youth, all of whom shall serve ex officiis, and eight other persons to be appointed by the governor. Such persons shall have demonstrated professional involvement and expertise in the area of delinquency prevention, rehabilitation, and treatment. Upon the expiration of the term of office of any appointive member, his successor shall be appointed for a term of three years. Any vacancy shall be filled by the governor for the remainder of the unexpired term. The governor shall appoint from the members of said committee a chairman and a vice chairman. The committee may appoint a full time executive secretary. Members of said committee shall serve without compensation, but each member shall be reimbursed by the commonwealth for all reasonable expenses incurred in the performance of his official duties.

Said advisory committee shall have the following duties: (a) It shall advise the commissioner on policy, program development and priorities of need in developing a comprehensive program (1) for the treatment, rehabilitation and custody of juvenile offenders and (2) for integration of the juvenile offender into constructive community life. (b) It shall review the annual plan and the proposed annual budget for the department, and shall make recommendations to the commissioner relative thereto. (c) It shall advise on the recruitment policies of the schools in the department. (d) It shall submit an annual report in which it may propose legislation and present material for the education of the public. (e) It shall visit, at its discretion, every institution and facility within the jurisdiction of the department. It shall meet at least four times a year and shall convene special meetings at the call of the chairman of the committee, a majority of the committee, or the commissioner. For the purposes of holding meetings and conducting official business, a majority of the membership shall constitute a quorum.

A written record of all meetings of the committee shall be maintained by the executive secretary and a copy filed within fifteen days after each meeting by said secretary with the commissioner of administration and finance.

*Chapter 30**

Section 9B. *Protecting Certain Public Officers and Employees of the Commonwealth Against Arbitrary Removal.*—No person permanently employed in any institution under the department of mental health, public health, public welfare, correction or youth services, or in the soldiers' homes in Massachusetts, except an employee, other than a nurse, rendering professional service, who is not classified under chapter thirty-one, and no maintenance employee permanently employed in any institution under the department of education, shall, after having actually performed the duties of any office or position continuously for a period of six months in such an institution or department, be discharged, removed, suspended, laid off, transferred from the latest permanent office or employment held by him without his consent, lowered in rank or compensation, nor shall his office or position be abolished, except for just cause and in the manner provided by sections forty-three and forty-five of chapter thirty-one. The provisions of section forty-six A of said chapter thirty-one shall apply to any person so employed.

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Section 9D. *Tenure for Teachers Permanently Employed in Certain State Institutions, etc., After Three Years' Service.*—No person permanently employed as a teacher in any institution under the department of mental health, public health, public welfare, correction, or youth services, who is not classified under chapter thirty-one, shall, after having served as such teacher for a period of three years in such institution, be discharged, removed, suspended, laid off, transferred without his consent, lowered in rank or compensation, nor shall his office or position be abolished, except for just cause and in the manner provided by sections forty-three and forty-five of said chapter thirty-one.

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Section 24A. *Compensation of State Employees Required to Work on a Legal Holiday; Exceptions.*—If any person employed by the commonwealth is required to work on any legal holiday, as listed in the first sentence of clause Eighteenth of section seven of chapter four, he shall be given an additional day off or, if such additional day off cannot be given by reason of a personnel shortage or other cause, he shall be entitled to an additional day's pay; provided, that any person whose regular day off, other than a Saturday, falls on any such legal holiday shall be given an additional day off or, if such additional day off cannot be given by reason of a personnel shortage or other cause, an additional day's pay; and provided, further, that if the regular day off of any such person is Saturday and any such legal holiday falls on a Saturday, such person shall, where possible, be given the preceding Friday off without loss of pay, or if said day off cannot be given by reason of a personnel shortage or other cause, he shall be given an additional day off, as hereinbefore provided for other persons whose regular day off falls on a legal holiday, or, in lieu thereof, an additional day's pay.

This section shall not apply to elected officers, appointees of the governor, heads of departments and divisions, superintendents of institutions in the departments of mental health, public health, public welfare, Soldiers' Home in Massachusetts, Soldiers' Home in Holyoke and agencies under the jurisdiction of the department of youth services, to presidents of educational institutions or to principal officers in the correctional institutions.

Chapter 30A

State Administrative Procedure

Section 1. For the purposes of this chapter—

(1) "Adjudicatory proceeding" means a proceeding before an agency in which the legal rights, duties or privileges of specifically named persons are required by constitutional right or by any provision of the General Laws to be determined after opportunity for an agency hearing. Without enlarging the scope of this definition, adjudicatory proceeding does not include (a) proceedings solely to determine whether the agency shall institute or recommend institution of proceedings in a court; or (b) proceedings for the arbitration of labor disputes voluntarily submitted by the parties to such disputes; or (c) proceedings for the dis-

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* **Above sections were amended by St. 838, Acts of 1969.**

position of grievances of employees of the commonwealth; or (d) proceedings to classify or reclassify, or to allocate or reallocate, appointive offices and positions in the government of the commonwealth.

(2) "Agency" includes any department, board, commission, division or authority of the state government, or subdivision of any of the foregoing, or official of the state government, authorized by law to make regulations or to conduct adjudicatory proceedings, but does not include the following; the legislative and judicial departments; the governor and council; military or naval boards, commissions or officials; the department of correction; the department of youth services; the parole board; the division of industrial accidents of the department of labor and industries; the division of child guardianship of the department of public welfare; the division of civil service; and the director of civil service and the welfare compensation board.

Chapter 77

School Offenders and County Training Schools

SECTION 3. (Amended by St. 838, Acts of 1969). *Habitual truants.*—A child between seven and sixteen who wilfully and habitually absents himself from school contrary to section one of chapter seventy-six shall be deemed an habitual truant, and, unless placed on probation as provided in section seven, may, on complaint of a supervisor of attendance, be committed, until he reaches his sixteenth birthday, to the county training school, if any, maintained within the county wherein he resides or, if there is no such school, to the custody of the department of youth services or to a county training school; provided that no girl shall be committed to a county training school under this section, but may be committed to the custody of the department of youth services.

SECTION 4. (Amended by St. 838, Acts of 1969). *Habitual absentees.*—A child between seven and sixteen found wandering about the streets or public places, having no lawful occupation, habitually absent from school and growing up in idleness and ignorance, shall be deemed an habitual absentee, and, unless placed on probation as provided in section seven, may, on complaint of a supervisor of attendance or any other person, be committed, until he reaches his sixteenth birthday, to the county training school, if any, maintained within the county wherein he resides or, if there is no such school, to the custody of the department of youth services, or to a county training school; provided, that no girl shall be committed to a county training school under this section, but may be committed to the custody of the department of youth services.

SECTION 5. (Amended by 838, Acts of 1969). *Habitual school offenders.*—A child under sixteen persistently violating reasonable regulations of the school he attends, or otherwise persistently misbehaving therein, so as to render himself a fit subject for exclusion therefrom, shall be deemed an habitual school offender, and, unless placed on probation as provided in section seven, may, on complaint of a supervisor of attendance, be committed, until he reaches his sixteenth birthday, to the county training school, if any, maintained within the county wherein he resides or, if there is no such school, to the custody of the department of youth services, or to a county training school; provided, that no girl shall be committed to a county training school under this section, but may be committed to the custody of the department of youth services.

SECTION 6. *Support of inmates.*—The court or magistrate by whom a child has been committed to a county training school may make an order relative to the payment by his parents or by his guardian out of the ward's property to the county of the cost of his support while in said school, and may from time to time revise or alter such order or make a new order as the circumstances of the parents or ward may justify.

SECTION 7. *Probation.*—A court or magistrate by whom a child has been convicted of an offence under this chapter may place him on probation under the oversight of a supervisor of attendance of the town where the child resides, or of a probation officer of said court, for such period and upon such conditions as the court or magistrate may deem best; and if, with such period, the child violates the conditions of his probation, such supervisor of attendance or probation officer may, without warrant or other process, take the child before the court, who may thereupon sentence him or may make any other lawful disposition of the case.

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SECTION 10. *Disposition of unruly inmates.*—An inmate of a county training school persistently violating reasonable regulations thereof, or guilty of indecent or immoral conduct, or otherwise grossly misbehaving, so as to render himself an unfit subject for retention therein, may, on complaint of the officer in control of said school be committed to the youth service board.

SECTION 11. (Amended by St. 859, Acts of 1969). *Jurisdiction.*—The Boston juvenile court, the Worcester juvenile court and the Springfield juvenile court and the district courts, except the municipal and district courts, located within the territorial limits of said juvenile courts, shall have jurisdiction of offenses arising under section one of chapter seventy-six and under this chapter. A summons or warrant issued by such court or justice may be served, at the discretion of the court or justice, by a supervisor of attendance or by any officer qualified to serve criminal process. On complaint against a child for any such offense his parents, guardian or custodian shall be notified as required by section fifty-five of chapter one hundred and nineteen. A child against whom complaint as an habitual absentee is brought by any other person than a supervisor of attendance shall not be committed until notice and an opportunity to be heard have been given to the youth service board.

SECTION 12. *Supervisors of attendance.*—Every school committee shall appoint, make regulations governing and fix the compensation of one or more supervisors of attendance, who may be either male or female, and who shall meet such standards of qualification for such work as shall be established by the department of education. Such supervisors shall not receive fees for their services. The committees of two or more towns may employ the same supervisors of attendance.

SECTION 13. *Same subject; duties.*—Supervisors of attendance shall inquire into all cases arising under section eight of chapter seventy-two, sections one, two, four to eleven, inclusive, and fifteen of chapter seventy-six, sections three, four, five and eight of this chapter and sections ninety, ninety-two, ninety-three and ninety-five of chapter one hundred and forty-nine, and may make complaints and serve legal processes issued under this chapter. They shall, if the court so orders, have oversight of children placed on probation under section seven; of minors licensed by the school committee under section nineteen of chapter one hundred and one; and of children admitted to or attending shows or entertainments contrary to section one hundred and ninety-seven of chapter one hundred and forty. They may apprehend and take to school without a warrant any truant or absentee found wandering in the streets or public places.

SECTION 14. *Elimination of references to certain acts.*—Nothing contained in this chapter shall affect chapter seven hundred and thirty-eight of the acts of nineteen hundred and fourteen relative to truants, absentees and school offenders in Boston.

Chapter 111

SECTION 4D. (Amended by St. 838, Acts of 1969). There shall be an advisory council on alcoholism, consisting of the commissioners of education, public health, public welfare, mental health, public safety, correction, and youth services, the chairman of the parole board, the commissioner of probation, the registrar of motor vehicles, the commissioner of rehabilitation, and three members appointed by the governor for terms of three years each. Such appointive members shall have had experience in some field connected with the care and treatment of alcoholics. The commissioner of public health shall serve as chariman.

The advisory council shall meet at least twice a year, and shall meet at any time upon call of the chairman. It shall consider and make recommendations to the commissioner of public health as to the care and treatment of alcoholics and as to the assembling and dissemination of knowledge regarding the problem of alcoholism. For services on the council, its members shall receive no compensation, but they shall receive their expenses necessarily incurred in rendering such service

Chapter 119

Protection of Children

SECTION 3. *Definitions.* The following words and phrases when used in sections one to thirty-nine, inclusive, shall, unless the context otherwise requires, be construed as follows:—

"Department", shall mean the department of public welfare.

"Parent", means mother or father, unless specified parent as defined under section one of chapter one hundred and eighteen.

"Custody", shall include the following powers:—(1) to determine the child's place of abode, medical care and education, (2) to control visits to the child; (3) to consent to enlistments, marriages and other contracts otherwise requiring parental consent. In the event that the parent or guardian shall object to the carrying out of any power conferred by this paragraph, said parent or guardian may make application to the committing court and said court shall review and make an order on the matter.

"Evidence", shall be admissible according to the rules of the common law and the General Laws and may include reports to the court by any person who has made an investigation of the facts relating to the welfare of the child and is qualified as an expert according to the rules of the common law or by statute or is an agent of the department or of an approved charitable corporation or agency substantially engaged in the foster care or protection of children. Such person may file with the court in a proceeding under said sections a report in full of all the facts obtained as a result of such investigation. The person reporting may be called as a witness by any party for examination as to the statements made in the report. Such examination shall be conducted as though it were on cross-examination.

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SECTION 8. *Visits to independent foster homes; investigations; recommendations.*—The department may visit any independent foster home for children and shall visit at least annually any home where two or more unrelated children are boarded for financial consideration. Upon receipt of notice or any information of the placement or reception of a child described in sections one to seven, inclusive, an agent of the department may enter without actual force any building or room where such child is sheltered and maintained, and may investigate the case and make such recommendations as are deemed expedient.

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SECTION 11. *Advertisement or notice in newspapers for placement or reception of children for board; approval.*—No person shall cause to be published in a newspaper circulated in the commonwealth an advertisement or notice for the placement or reception of a child under sixteen years of age for board, for giving it a home, or for adoption unless such advertisement is placed by the department under sections fourteen to twenty-two, inclusive, or an independent foster home for children licensed under section five, or unless with the written approval of the department.

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SECTION 33. *Protection of religious beliefs.*—No parents or surviving parent of any minor child in the care or under the supervision of the department or of any state, county or local department, or of any state, county or local board of trustees, or of any private charitable or child-care agency, shall be denied the right of any child of theirs to the free exercise of the religious belief of his parents and the liberty of worshipping God according to the religion of his parents or surviving parent, or of the religion which his parents professed if they are both deceased; and no minor child in the care or under the supervision of the department or of any state, county or local department, or state, county or local board of trustees, or of any private charitable or child-care agency, shall be denied the free exercise of the religion of his parents, or of his surviving parent, or of his parents if they are both deceased, nor the liberty of worshipping God according to the religion of his parents, whether living or deceased.

When a child is placed in family home care, any of the above named departments, boards or agencies, shall use a family home of the same religious faith as that of the child unless sufficient reason precludes this, which reason must be a part of the record of the child's care. The words "same religious faith" shall in the case of any denomination of the Protestant religion include any other denomination of the same religion.

SECTION 34. *Transportation of children in patrol wagons.*—A child involved in any proceeding shall not be transported in a patrol wagon from his home or from any other place to any court or institution, but if a conveyance is necessary shall convey him in such other suitable vehicle as shall be provided or designated by the department. Violation of this section shall be punished by a fine of not less than twenty-five nor more than fifty dollars or by imprisonment for not more than three months.

SECTION 35. *Furnishing parent or guardian information as to child; permission to visit; petition; notice.*—If the parent or guardian of a child placed in charge of any person, association or public or private institution by any state department, town board, or by any public or private corporation or body of persons authorized by law to so place children, or if one of the next of kin of an orphan so placed in charge and without guardian, is not, upon request, informed by such department, board, corporation or body of persons where the child is, the probate court for the county where such child has his legal residence may, upon petition of such parent, guardian or next of kin, and upon notice, if in its opinion the welfare of the child and the public interest will not be injured thereby, require such department, board, corporation or body of persons where the child is, the probate court for the county where such child has his legal residence may, upon petition of such parent, guardian or next of kin, and upon notice, if in its opinion the welfare of the child and the public interest will not be injured thereby, require such department board, corporation or body of persons to give the information and permit the parent, guardian or next of kin to visit the child at such times and under such conditions as the court orders; and the court may revise its order or make new orders or decrees as the welfare of the child and the public interest may require.

SECTION 36. *Bringing child into commonwealth with view to adoption, custody or care; permit; application; bond.*—No person or institution shall bring or cause to be brought into the commonwealth, or receive therein, from any other state, province or country, any child for the purpose of placing or boarding, or of procuring the placing or boarding of such child, in a family or home within the commonwealth, with a view to adoption, guardianship, custody or care by any person other than one related to him by blood or marriage, without first obtaining a permit therefor from the department. Such a permit shall not issue until a written application therefor has been filed with the department on forms by it prepared, containing such information relative to such child as the department may require, accompanied by an individual or blanket bond running to the commonwealth in such penal sum and with such surety or sureties as the department may approve, conditioned on the following:—(1) that all statements contained in such an application are true in substantial particulars; (2) that any such child becoming a public charge during his minority shall be removed from the state not later than thirty days after notice from the department; (3) that such child shall be removed from the state immediately upon his release from any penal or reformatory institution or training school to which he has been committed, within three years of his arrival within the state, for juvenile delinquency or crime; (4) that such child shall be placed or boarded under such agreement as will secure to him a proper home and surroundings, and as will render his custodian responsible for his proper care, education and training, under adequate supervision and subject to annual visitation by an agent; and (5) that such reports relative to the child shall be made to the department as it may require. In case of a breach of any condition of such a bond, the attorney general, upon request of the department, shall put the bond in suit, and the commonwealth or any city or town thereof shall be reimbursed from the proceeds for any expense incurred by reason of a breach of any such condition. Violation of this section shall be punished by a fine of not more than one hundred dollars or by imprisonment for not more than six months, or both.

Delinquent Children

SECTION 52. (Amended by St. 859, Acts of 1969). Definitions. The following words as used in the following sections shall, except as otherwise specifically provided, have the following meanings:

"Court", the Boston juvenile court, the Worcester juvenile court, the Springfield juvenile court or a district court, except the municipal court of the city of Boston, the municipal court of the Roxbury district, the central district court of Worcester and the district court of Springfield.

"Delinquent child", a child between seven and seventeen who violates any city ordinance or town by-law or who commits any offence against a law of the commonwealth.

"Probation officer", a probation officer or assistant probation officer of the court having jurisdiction of the pending case.

"Wayward child", a child between seven and seventeen years of age who habitually associates with vicious or immoral persons, or who is growing up in circumstances exposing him to lead an immoral, vicious or criminal life.

SECTION 53. *Liberal construction; nature of proceedings.*—Sections fifty-two to sixty-three, inclusive, shall be liberally construed so that the care, custody and discipline of the children brought before the court shall approximate as nearly as possible that which they should receive from their parents, and that, as far as practicable, they shall be treated, not as criminals, but as children in need of aid, encouragement and guidance. Proceedings against children under said sections shall not be deemed criminal proceedings.

SECTION 54. *Proceedings; complaint; examination of complainant; summons; warrant.*—If complaint is made to any court that child between seven and seventeen years of age is a wayward child or a delinquent child, said court shall examine, on oath the complainant and the witnesses, if any, produced by him, and shall reduce the complaint to writing, and cause it to be subscribed by the complainant.

If said child is under twelve years of age, said court shall first issue a summons requiring him to appear before it at the time and place named therein, and such summons shall be issued in all other cases, instead of a warrant, unless the court has reason to believe that he will not appear upon summons, in which case, or if such a child has been summoned and did not appear, said court may issue a warrant reciting the substance of the complaint, and requiring the officer to whom it is directed forthwith to take such child and bring him before said court, to be dealt with according to law, and to summon the witnesses named therein to appear and give evidence at the examination.

SECTION 55. (Amended by St. 838, Acts of 1969). *Summoning of parent or guardian; service; agent of the dept. of youth services; notice.*—If a child has been summoned to appear or is brought before such court upon a warrant, as provided in section fifty-four, a summons shall be issued to at least one of its parents, if either of them is known to reside within the commonwealth, and, if there is no such parent, then to its lawful guardian, if there is one known to be so resident, and if not, then to the person with whom such child resides, if known. Said summons shall require the person served to appear at a time and place stated therein, and show cause why such child should not be adjudged a wayward child or delinquent child, as the case may be. If there is no such parent, guardian or person who can be summoned as aforesaid, the court may appoint a suitable person to act for such child.

If such child is summoned, the time for appearance fixed in the summons to a parent, guardian or other person, as herein provided, shall, when practicable, be that fixed for the appearance of said child.

A summons required by this and said section fifty-four, unless service thereof is waived in writing, shall be served by a constable or police officer, by delivering it personally to the person to whom addressed, or by leaving it with a person of proper age to receive the same, at the place of residence or business of such person; and said constable or officer shall immediately make return to the court of the time and manner of the service.

If the court shall be of the opinion that the interests of the child require the attendance at any proceedings of an agent of the department of youth services and shall request such attendance by reasonable notice to the commissioner of youth services, such agent shall attend to protect the interests of said child.

SECTION 56. (Amended by St. 308, Acts of 1964) *Hearing; appeal to superior court; juvenile session; report of investigation.*—Hearings upon cases arising under sections fifty-two to sixty-three, inclusive, may be adjourned from time to time. A child adjudged a wayward child or delinquent child may appeal to the superior court upon adjudication, and also may appeal to said court at the time of the order of commitment or sentence, and such child shall, at the time of such adjudication and also at the time of such order of commitment or sentence, be notified of his right to appeal. If such child appeals to the superior court at either of said times, said court shall thereupon have jurisdiction of such case, and such case shall forthwith be entered in said court. The appeal, if taken, shall be tried and determined in like manner as appeals in criminal cases, except that the trial of said appeals in the superior court shall not be in conjunction with the other business of that court, but shall be held in a session set apart and devoted for the time being exclusively to the trial of juvenile cases. This shall be known as the juvenile session of the superior court, and shall have a separate trial list and docket. All appealed juvenile cases in the superior court shall be transferred to this list, and shall be tried, unless otherwise disposed of by direct order of the court. In any appealed case, if the allegations with respect to such child are proven, the superior court shall not commit such child to any correctional institution, jail or house of correction, but may adjudicate such child to be a wayward child or a delinquent child, and may make such disposition as may be made by a court under section fifty-eight. Before making such disposition, the superior court shall be supplied with a report of any investigation regarding the child made by the probation officer of the court from which the appeal was taken. Section thirty-five of chapter two hundred and seventy-six and section eighteen of chapter two hundred and seventy-eight, relative to recognizances in cases continued or appealed, shall apply to cases arising under sections fifty-two to sixty-three, inclusive.

SECTION 57. *Investigation by probation officer; record of performance; reports.*—Every case of a wayward child or a delinquent child shall be investigated by the probation officer, who shall make a report regarding the character of such child, his school record, home surroundings and the previous complaints against him, if any. In every case involving a child attending a special class authorized by law, he shall secure from the bureau of special education a record of performance of said child. He shall be present in court at the trial of the case, and furnish the court with such information and assistance as shall be required. At the end of the probation period of a child who has been placed on probation, the officer in whose care he has been shall make a report as to his conduct during such period.

SECTION 58. (Amended by St. 838 and 859, Acts of 1969). *Adjudication; proceedings after adjudication; placement in care of probation officer; commitment to custody of department of youth services; payment for support of child.*—At the hearing of a complaint against a child the court shall hear the testimony of any witnesses that appear and take such evidence relative to the case as shall be produced. If the allegations against a child are proved beyond a reasonable doubt, he may be adjudged a wayward child or a delinquent child.

If a child is adjudged a delinquent child, the court may place the case on file, or may place the child in the care of a probation officer for such time and on such conditions as may seem proper, or may commit him to the custody of the department of youth services. If it is alleged in the complaint upon which the child is so adjudged that a penal law of the commonwealth, a city ordinance or a town by-law has been violated or, in the cases of habitual school offenders and truancy violations, the court may commit such child to the custody of the commissioner of youth services and authorize him to place such child in the charge of any person, and, if at any time thereafter the child proves unmanageable, to transfer such child to the facility or training school which in the opinion of said commissioner, after study, will best serve the needs of the child, but not for a longer period than until such child becomes twenty-one. The department of youth services shall provide for the maintenance, in whole or in part, of any child so placed in the charge of any person.

If a child adjudged a wayward child or delinquent child is placed on probation by the superior court, he may be placed in the care of a probation officer of the district court, including in that term the Boston, the Worcester and the Springfield juvenile courts, within the judicial district in which such child resides.

The court may commit such wayward or delinquent child to the department of youth services, but it shall not commit such child to a jail or house of correction, nor to the Lyman school, the industrial school for boys, or the industrial school for girls, nor to any other institution supported by the commonwealth for the custody, care and training of delinquent or wayward children or juvenile offenders.

The court may make an order for payment by the child's parents or guardian from the child's property, or by any other person responsible for the care and support of said child, to the institution, department, division, organization or person furnishing care and support at times to be stated in an order by the court of sums not exceeding the cost of said support after ability to pay has been determined by the court; provided, that no order for the payment of money shall be entered until the person by whom payments are to be made shall have been summoned before the court and given an opportunity to be heard. The court may from time to time, upon petition by, or notice to the person ordered to pay such sums of money, revise or alter such order or make a new order, as the circumstances may require.

SECTION 58A. *Repealed.*

SECTION 58B. *Commitment of delinquent child; non-criminal fines for violation of motor vehicle laws.*—If, under the provisions of section fifty-eight, a child is adjudged a delinquent child by reason of having violated any statute, by-law, ordinance or regulation relating to the operation of motor vehicles, the court may place the case on file or may place the child in the care of a probation officer, or may commit him to the custody of the department of youth services, as provided in section fifty-eight, and may require restitution as provided in section sixty-two; and in addition to or in lieu of such disposition, the court may impose upon such child a fine not exceeding the amount of the fine authorized for the violation of such statute, by-law, ordinance or regulation. Any fine imposed under the authority of this section shall be collected, recovered and paid over in the manner provided by chapters two hundred and seventy-nine and two hundred and eighty; provided, however, that if any child shall neglect, fail or refuse to pay a fine imposed under this section, he may be arrested upon order of the court and brought before the court, which may thereupon place him in the care of a probation officer or commit him to the custody of the department of youth services; but no such child shall be committed to any jail, house of correction, or correctional institution of the commonwealth. The provisions of sections sixty and sixty A shall apply to any case disposed of under this section; provided, however, that the court shall provide the registrar of motor vehicles with an abstract of every such adjudication and disposition, in the manner provided by section twenty-seven of chapter ninety; and provided, further, that such adjudication and disposition

"Evidence", shall be admissible according to the rules of the common law and the General Laws and may include reports to the court by any person who has made an investigation of the facts relating to the welfare of the child and is qualified as an expert according to the rules of the common law or by statute or is an agent of the department or of an approved charitable corporation or agency substantially engaged in the foster care or protection of children. Such person may file with the court in a proceeding under said sections a report in full of all the facts obtained as a result of such investigation. The person reporting may be called as a witness by any party for examination as to the statements made in the report. Such examination shall be conducted as though it were on cross-examination.

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SECTION 8. *Visits to independent foster homes; investigations; recommendations.*—The department may visit any independent foster home for children and shall visit at least annually any home where two or more unrelated children are boarded for financial consideration. Upon receipt of notice or any information of the placement or reception of a child described in sections one to seven, inclusive, an agent of the department may enter without actual force any building or room where such child is sheltered and maintained, and may investigate the case and make such recommendations as are deemed expedient.

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SECTION 11. *Advertisement or notice in newspapers for placement or reception of children for board; approval.*—No person shall cause to be published in a newspaper circulated in the commonwealth an advertisement or notice for the placement or reception of a child under sixteen years of age for board, for giving it a home, or for adoption unless such advertisement is placed by the department under sections fourteen to twenty-two, inclusive, or an independent foster home for children licensed under section five, or unless with the written approval of the department.

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SECTION 33. *Protection of religious beliefs.*—No parents or surviving parent of any minor child in the care or under the supervision of the department or of any state, county or local department, or of any state, county or local board of trustees, or of any private charitable or child-care agency, shall be denied the right of any child of theirs to the free exercise of the religious belief of his parents and the liberty of worshipping God according to the religion of his parents or surviving parent, or of the religion which his parents professed if they are both deceased; and no minor child in the care or under the supervision of the department or of any state, county or local department, or state, county or local board of trustees, or of any private charitable or child-care agency, shall be denied the free exercise of the religion of his parents, or of his surviving parent, or of his parents if they are both deceased, nor the liberty of worshipping God according to the religion of his parents, whether living or deceased.

When a child is placed in family home care, any of the above named departments, boards or agencies, shall use a family home of the same religious faith as that of the child unless sufficient reason precludes this, which reason must be a part of the record of the child's care. The words "same religious faith" shall in the case of any denomination of the Protestant religion include any other denomination of the same religion.

SECTION 34. *Transportation of children in patrol wagons.*—A child involved in any proceeding shall not be transported in a patrol wagon from his home or from any other place to any court or institution, but if a conveyance is necessary shall convey him in such other suitable vehicle as shall be provided or designated by the department. Violation of this section shall be punished by a fine of not less than twenty-five nor more than fifty dollars or by imprisonment for not more than three months.

SECTION 35. *Furnishing parent or guardian information as to child; permission to visit; petition; notice.*—If the parent or guardian of a child placed in charge of any person, association or public or private institution by any state department, town board, or by any public or private corporation or body of persons authorized by law to so place children, or if one of the next of kin of an orphan so placed in charge and without guardian, is not, upon request, informed by such department, board, corporation or body of persons where the child is, the probate court for the county where such child has his legal residence may, upon petition of such parent, guardian or next of kin, and upon notice, if in its opinion the welfare of the child and the public interest will not be injured thereby, require such department, board, corporation or body of persons where the child is, the probate court for the county where such child has his legal residence may, upon petition of such parent, guardian or next of kin, and upon notice, if in its opinion the welfare of the child and the public interest will not be injured thereby, require such department board, corporation or body of persons to give the information and permit the parent, guardian or next of kin to visit the child at such times and under such conditions as the court orders; and the court may revise its order or make new orders or decrees as the welfare of the child and the public interest may require.

SECTION 36. *Bringing child into commonwealth with view to adoption, custody or care; permit; application; bond.*—No person or institution shall bring or cause to be brought into the commonwealth, or receive therein, from any other state, province or country, any child for the purpose of placing or boarding, or of procuring the placing or boarding of such child, in a family or home within the commonwealth, with a view to adoption, guardianship, custody or care by any person other than one related to him by blood or marriage, without first obtaining a permit therefor from the department. Such a permit shall not issue until a written application therefor has been filed with the department on forms by it prepared, containing such information relative to such child as the department may require, accompanied by an individual or blanket bond running to the commonwealth in such penal sum and with such surety or sureties as the department may approve, conditioned on the following:—(1) that all statements contained in such an application are true in substantial particulars; (2) that any such child becoming a public charge during his minority shall be removed from the state not later than thirty days after notice from the department; (3) that such child shall be removed from the state immediately upon his release from any penal or reformatory institution or training school to which he has been committed, within three years of his arrival within the state, for juvenile delinquency or crime; (4) that such child shall be placed or boarded under such agreement as will secure to him a proper home and surroundings, and as will render his custodian responsible for his proper care, education and training, under adequate supervision and subject to annual visitation by an agent; and (5) that such reports relative to the child shall be made to the department as it may require. In case of a breach of any condition of such a bond, the attorney general, upon request of the department, shall put the bond in suit, and the commonwealth or any city or town thereof shall be reimbursed from the proceeds for any expense incurred by reason of a breach of any such condition. Violation of this section shall be punished by a fine of not more than one hundred dollars or by imprisonment for not more than six months, or both.

Delinquent Children

SECTION 52. (Amended by St. 859, Acts of 1969). Definitions. The following words as used in the following sections shall, except as otherwise specifically provided, have the following meanings:

"Court", the Boston juvenile court, the Worcester juvenile court, the Springfield juvenile court or a district court, except the municipal court of the city of Boston, the municipal court of the Roxbury district, the central district court of Worcester and the district court of Springfield.

"Delinquent child", a child between seven and seventeen who violates any city ordinance or town by-law or who commits any offence against a law of the commonwealth.

"Probation officer", a probation officer or assistant probation officer of the court having jurisdiction of the pending case.

"Wayward child", a child between seven and seventeen years of age who habitually associates with vicious or immoral persons, or who is growing up in circumstances exposing him to lead an immoral, vicious or criminal life.

SECTION 53. *Liberal construction; nature of proceedings.*—Sections fifty-two to sixty-three, inclusive, shall be liberally construed so that the care, custody and discipline of the children brought before the court shall approximate as nearly as possible that which they should receive from their parents, and that, as far as practicable, they shall be treated, not as criminals, but as children in need of aid, encouragement and guidance. Proceedings against children under said sections shall not be deemed criminal proceedings.

SECTION 54. *Proceedings; complaint; examination of complainant; summons; warrant.*—If complaint is made to any court that child between seven and seventeen years of age is a wayward child or a delinquent child, said court shall examine, on oath the complainant and the witnesses, if any, produced by him, and shall reduce the complaint to writing, and cause it to be subscribed by the complainant.

If said child is under twelve years of age, said court shall first issue a summons requiring him to appear before it at the time and place named therein, and such summons shall be issued in all other cases, instead of a warrant, unless the court has reason to believe that he will not appear upon summons, in which case, or if such a child has been summoned and did not appear, said court may issue a warrant reciting the substance of the complaint, and requiring the officer to whom it is directed forthwith to take such child and bring him before said court, to be dealt with according to law, and to summon the witnesses named therein to appear and give evidence at the examination.

SECTION 55. (Amended by St. 838, Acts of 1969). *Summoning of parent or guardian; service; agent of the dept. of youth services; notice.*—If a child has been summoned to appear or is brought before such court upon a warrant, as provided in section fifty-four, a summons shall be issued to at least one of its parents, if either of them is known to reside within the commonwealth, and, if there is no such parent, then to its lawful guardian, if there is one known to be so resident, and if not, then to the person with whom such child resides, if known. Said summons shall require the person served to appear at a time and place stated therein, and show cause why such child should not be adjudged a wayward child or delinquent child, as the case may be. If there is no such parent, guardian or person who can be summoned as aforesaid, the court may appoint a suitable person to act for such child.

If such child is summoned, the time for appearance fixed in the summons to a parent, guardian or other person, as herein provided, shall, when practicable, be that fixed for the appearance of said child.

A summons required by this and said section fifty-four, unless service thereof is waived in writing, shall be served by a constable or police officer, by delivering it personally to the person to whom addressed, or by leaving it with a person of proper age to receive the same, at the place of residence or business of such person; and said constable or officer shall immediately make return to the court of the time and manner of the service.

If the court shall be of the opinion that the interests of the child require the attendance at any proceedings of an agent of the department of youth services and shall request such attendance by reasonable notice to the commissioner of youth services, such agent shall attend to protect the interests of said child.

SECTION 56. (Amended by St. 308, Acts of 1964) *Hearing; appeal to superior court; juvenile session; report of investigation.*—Hearings upon cases arising under sections fifty-two to sixty-three, inclusive, may be adjourned from time to time. A child adjudged a wayward child or delinquent child may appeal to the superior court upon adjudication, and also may appeal to said court at the time of the order of commitment or sentence, and such child shall, at the time of such adjudication and also at the time of such order of commitment or sentence, be notified of his right to appeal. If such child appeals to the superior court at either of said times, said court shall thereupon have jurisdiction of such case, and such case shall forthwith be entered in said court. The appeal, if taken, shall be tried and determined in like manner as appeals in criminal cases, except that the trial of said appeals in the superior court shall not be in conjunction with the other business of that court, but shall be held in a session set apart and devoted for the time being exclusively to the trial of juvenile cases. This shall be known as the juvenile session of the superior court, and shall have a separate trial list and docket. All appealed juvenile cases in the superior court shall be transferred to this list, and shall be tried, unless otherwise disposed of by direct order of the court. In any appealed case, if the allegations with respect to such child are proven, the superior court shall not commit such child to any correctional institution, jail or house of correction, but may adjudicate such child to be a wayward child or a delinquent child, and may make such disposition as may be made by a court under section fifty-eight. Before making such disposition, the superior court shall be supplied with a report of any investigation regarding the child made by the probation officer of the court from which the appeal was taken. Section thirty-five of chapter two hundred and seventy-six and section eighteen of chapter two hundred and seventy-eight, relative to recognizances in cases continued or appealed, shall apply to cases arising under sections fifty-two to sixty-three, inclusive.

SECTION 57. *Investigation by probation officer; record of performance; reports.*—Every case of a wayward child or a delinquent child shall be investigated by the probation officer, who shall make a report regarding the character of such child, his school record, home surroundings and the previous complaints against him, if any. In every case involving a child attending a special class authorized by law, he shall secure from the bureau of special education a record of performance of said child. He shall be present in court at the trial of the case, and furnish the court with such information and assistance as shall be required. At the end of the probation period of a child who has been placed on probation, the officer in whose care he has been shall make a report as to his conduct during such period.

SECTION 58. (Amended by St. 838 and 859, Acts of 1969). *Adjudication; proceedings after adjudication; placement in care of probation officer; commitment to custody of department of youth services; payment for support of child.*—At the hearing of a complaint against a child the court shall hear the testimony of any witnesses that appear and take such evidence relative to the case as shall be produced. If the allegations against a child are proved beyond a reasonable doubt, he may be adjudged a wayward child or a delinquent child.

If a child is adjudged a delinquent child, the court may place the case on file, or may place the child in the care of a probation officer for such time and on such conditions as may seem proper, or may commit him to the custody of the department of youth services. If it is alleged in the complaint upon which the child is so adjudged that a penal law of the commonwealth, a city ordinance or a town by-law has been violated or, in the cases of habitual school offenders and truancy violations, the court may commit such child to the custody of the commissioner of youth services and authorize him to place such child in the charge of any person, and, if at any time thereafter the child proves unmanageable, to transfer such child to the facility or training school which in the opinion of said commissioner, after study, will best serve the needs of the child, but not for a longer period than until such child becomes twenty-one. The department of youth services shall provide for the maintenance, in whole or in part, of any child so placed in the charge of any person.

If a child adjudged a wayward child or delinquent child is placed on probation by the superior court, he may be placed in the care of a probation officer of the district court, including in that term the Boston, the Worcester and the Springfield juvenile courts, within the judicial district in which such child resides.

The court may commit such wayward or delinquent child to the department of youth services, but it shall not commit such child to a jail or house of correction, nor to the Lyman school, the industrial school for boys, or the industrial school for girls, nor to any other institution supported by the commonwealth for the custody, care and training of delinquent or wayward children or juvenile offenders.

The court may make an order for payment by the child's parents or guardian from the child's property, or by any other person responsible for the care and support of said child, to the institution, department, division, organization or person furnishing care and support at times to be stated in an order by the court of sums not exceeding the cost of said support after ability to pay has been determined by the court; provided, that no order for the payment of money shall be entered until the person by whom payments are to be made shall have been summoned before the court and given an opportunity to be heard. The court may from time to time, upon petition by, or notice to the person ordered to pay such sums of money, revise or alter such order or make a new order, as the circumstances may require.

SECTION 58A. *Repealed.*

SECTION 58B. *Commitment of delinquent child; non-criminal fines for violation of motor vehicle laws.*—If, under the provisions of section fifty-eight, a child is adjudged a delinquent child by reason of having violated any statute, by-law, ordinance or regulation relating to the operation of motor vehicles, the court may place the case on file or may place the child in the care of a probation officer, or may commit him to the custody of the department of youth services, as provided in section fifty-eight, and may require restitution as provided in section sixty-two; and in addition to or in lieu of such disposition, the court may impose upon such child a fine not exceeding the amount of the fine authorized for the violation of such statute, by-law, ordinance or regulation. Any fine imposed under the authority of this section shall be collected, recovered and paid over in the manner provided by chapters two hundred and seventy-nine and two hundred and eighty; provided, however, that if any child shall neglect, fail or refuse to pay a fine imposed under this section, he may be arrested upon order of the court and brought before the court, which may thereupon place him in the care of a probation officer or commit him to the custody of the department of youth services; but no such child shall be committed to any jail, house of correction, or correctional institution of the commonwealth. The provisions of sections sixty and sixty A shall apply to any case disposed of under this section; provided, however, that the court shall provide the registrar of motor vehicles with an abstract of every such adjudication and disposition, in the manner provided by section twenty-seven of chapter ninety; and provided, further, that such adjudication and disposition shall be admissible as evidence in any proceeding for the revocation or restoration of the child's license to operate a motor vehicle and for the cancellation of a motor vehicle insurance policy covering the vehicle operated by such child, and in any action of tort arising out of the negligent operation of a motor vehicle by said child, to the same extent that such evidence would be admissible if said child were an adult.

SECTION. 59. *Violation of terms of probation.*—If a child has been placed in care of a probation officer, said officer, at any time before the final disposition of the case, may arrest such child without a warrant and take him before the court, or the court may issue a warrant for his arrest. When such child is before the court, it may make any disposition of the case which it might have made before said child was placed on probation, or may continue or extend the period of probation.

SECTION 60. *Admissibility of adjudication as delinquent child as evidence in subsequent proceeding other than delinquency proceeding; disqualification for public service.*—An adjudication of any child as a wayward child or delinquent child under sections fifty-two to fifty-nine, inclusive, or the disposition thereunder of any child so adjudicated, or any evidence given in any case arising under said sections, shall not be lawful or proper evidence against such child for any purpose in any proceeding in any court, and records in cases arising against any child under said sections shall not be received in evidence or used in any way in any such proceeding, except in subsequent proceedings for waywardness or delinquency against the same child and except in imposing sentence in any criminal proceeding against the same person; nor shall such adjudication or disposition or evidence operate to disqualify a child in any future examination, appointment, or application for public service under the government either of the commonwealth or of any political subdivision thereof.

SECTION 60A. *Public inspection of records of delinquency case; consent, inspection by child, parent or guardian.*—The records of the court or the superior court on appeal in all cases of waywardness or delinquency arising under sections fifty-two to fifty-nine, inclusive, shall be withheld from public inspection except with the consent of a justice of such court, but such records in any such case against any particular child shall be open, at all reasonable times, to the inspection of the child, his or her parent or parents, guardian and attorney, or any of them.

SECTION 61. *Disposition of complaint alleging commission of criminal offense by child between 14 and 17 years of age.*—If it be alleged in a complaint made under sections fifty-two to sixty-three, inclusive, that a child has committed an offense, against a law of the commonwealth, or has violated a city ordinance or town by-law and if such alleged offense or violation was committed while the child was between his fourteenth and seventeenth birthday, and if the court is of the opinion that the interests of the public require that he should be tried for said offense, or violation, instead of being dealt with as a delinquent child, the court may, after a hearing on said complaint, order it dismissed.

SECTION 62. *Restitution or reparation by child to injured person.*—If, in adjudging a person a delinquent child, the court finds, as an element of such delinquency that he has committed an act involving liability in a civil action, and such delinquent child is placed on probation, the court may require as a condition thereof, that he shall make restitution or reparation to the injured person to such an extent and in such sum as the court determines. If the payment is not made at once, it shall be made to the probation officer, who shall give a receipt therefor, keep a record of the payment, pay the money to said injured person, and keep on file his receipt therefor.

SECTION 63. (Amended by St. 859, Acts of 1969). *Inducing or abetting delinquency of child; imprisonment; release; suspension of sentence; recognizance; appeal.*—Any person who shall be found to have caused, induced, abetted, encouraged or contributed toward the waywardness or delinquency of a child, or to have acted in any way tending to cause or induce such waywardness or delinquency, may be punished by a fine of not more than five hundred dollars or by imprisonment for not more than one year, or both. The court may release on probation under section eighty-seven of chapter two hundred and seventy-six, subject to such orders as it may make as to future conduct tending to cause, induce or contribute to such waywardness or delinquency, or it may suspend sentence under section one of chapter two hundred and seventy-nine, or before trial with the defendant's consent, it may allow the defendant to enter into a recognizance, in such penal sum as the court may fix, conditioned to comply with such terms as the court may order for the promotion of the future welfare of the child, and the said case may then be placed on file. The provisions for appeal and and recognizance in section fifty-six shall be applicable to cases arising hereunder. The Boston juvenile court shall have jurisdiction, concurrent with the municipal court of the city of Boston and the municipal court of the Roxbury district, of complaints hereunder. The Worcester juvenile court shall have jurisdiction, concurrent with the central district court of Worcester, of complaints hereunder. The Springfield juvenile court shall have jurisdiction, concurrent with the district court of Springfield, of complaints hereunder.

SECTION 64. *Powers of commissioner of probation; annual report.*—The commissioner of probation may supervise the probation work for wayward and delinquent children and make necessary inquiries in regard to the same, and in his annual report may make such recommendations as he considers advisable for the improvement of methods of dealing with such children.

Provisions Common to all Proceedings Against Children

SECTION 65. *Juvenile sessions; presence of minors; exclusion of public.*—Courts shall designate suitable times for the hearing of cases of children under seventeen years of age, which shall be called the juvenile session, for which a separate docket and record shall be kept. Said session shall be separate from that for the trial of criminal cases, shall not, except as otherwise expressly provided, be held in conjunction with other business of the court, and shall be held in rooms not used for criminal trials; and in places where no separate juvenile court room is provided, hearings, so far as possible, shall be held in chambers. No minor shall be allowed to be present at any such hearing unless his presence is necessary, either as a party or as a witness; and the court shall exclude the general public from the room, admitting only such persons as may have a direct interest in the case. A complaint under section sixty-three may be heard in such juvenile session.

SECTION 66. *Detention of child in police station; commitment to jail, house of correction or state farm.*—Except as otherwise provided in section sixty-seven, and in section twelve of chapter one hundred and twenty, no child under seventeen years of age shall be detained by the police in a lockup, police station or house of detention pending arraignment, examination or trial by the court. Except as otherwise provided in section sixty-eight, no child under seventeen years of age shall be committed by the court to a jail or house of correction or to the state farm, pending further examination or trial by the court or pending any continuance of his case or pending the prosecution of an appeal to the superior court or upon adjudication as a delinquent child.

SECTION 67. (Amended by St. 838, Acts of 1969). *Notice of arrest of child to probation officer and parent or guardian; detention pending inquiry; release; request for detention pending hearing; notice of hearing; detention facilities; inspection.*—Whenever a child between seven and seventeen years of age is arrested with or without a warrant, as provided by law, the officer in charge of the police station or town lockup to which the child has been taken shall immediately notify the probation officer of the district court within whose judicial district such child was arrested and at least one of the child's parents, or, if there is no parent, the guardian or person with whom it is stated that such child resides, and shall inquire into the case. Pending such notice and inquiry, such child shall be detained. Upon the acceptance by the officer in charge of said police station or town lockup of the written promise of said parent, guardian or any other reputable person to be responsible for the presence of such child in court at the time and place when such child is to appear or upon the receipt of such officer in charge from said probation officer of a request for the release of such child to him, such child shall be released to said person giving such promise or to said probation officer making such request; provided, that, if the arresting officer requests in writing that a child between fourteen and seventeen years of age be detained, and if the court issuing a warrant for the arrest of a child between fourteen and seventeen years of age directs in the warrant that such child shall be held in safekeeping pending his appearance in court, or, if the probation officer shall so direct, such child shall be detained in a police station or town lockup, or place of temporary custody commonly referred to as a detention home of the department of youth services, or any other home approved by the department of youth services pending his appearance in court. In the event any such child is so detained, the officer in charge at the police station or town lockup shall notify the probation officer and parent or parents, guardian, or person with whom it is stated that such child resides of the detention of such child. Nothing contained in this section shall prevent the admitting of such child to bail in accordance with law. Said probation officer or officer in charge at the police station or town lockup shall notify such child and his parent or parents or guardian or person with whom it is stated that such child resides of the time and place of the hearing of his case. No child between fourteen and seventeen years of age shall be detained in a police station or town lockup unless the detention facilities for children at such police station or town lockup have received the approval in writing of the commissioner of youth services. The department of youth services shall make inspection at least annually of police stations or town lockups wherein children are detained. If no such approved detention facilities exist in any city or town, such city or town may contract with an adjacent city or town for the use of approved detention facilities in order to prevent children who are detained from coming in contact with adult prisoners. Nothing in this section shall permit a child between fourteen and seventeen years of age being detained in a jail or house of correction. A separate and distinct place shall be provided in police stations, town lockups or places of detention for such children.

SECTION 68. (Amended by St. 838, Acts of 1969). *Commitment of children held for examination or trial; department of youth services; detention houses of department of youth services; precedence of cases.*—A child between seven and seventeen years of age held by the court for further examination, trial or continuance, or for indictment and trial under the provisions of sections seventy-three to eighty-three, or to prosecute an appeal to the superior court, if unable to furnish bail, shall be committed by the court to the care of the department of youth services, a probation officer, a parent, guardian, or other responsible person who shall provide for his safekeeping; provided, however, that the appearance at such examination or trial, or at the prosecution of the appeal of such child, shall be the responsibility of the court for which he is being held in safekeeping.

The department of youth services may provide special foster homes, and places of temporary custody commonly referred to as detention homes of the department of youth services for the care, maintenance and safekeeping of such children between seven and seventeen years of age who may be committed by the court to said department under this section; provided, that no more than five such children shall be detained in any such special foster home at any one time.

A child between seven and seventeen years of age so committed by the court to jail or to the youth service board to await further examination or trial by the Boston juvenile court, the Worcester juvenile court, the Springfield juvenile court, a district court of the superior court shall be returned thereto within fifteen days after the date of the order of such commitment, and final disposition of the case shall thereupon be made by adjudication or otherwise, unless, in the opinion of the court, the interest of the child and the public otherwise require.

The provisions of section twenty-four of chapter two hundred twelve, relative to the precedence of cases of persons actually confined in prison and awaiting trial, shall apply to children held in detention facilities of the department of youth services under this section to prosecute appeals to the superior court, or held for indictment and trial under the provisions of section seventy-three to eighty-three inclusive.

Said probation officer shall have the same authority, rights and powers in relation to a child committed to his care under this section, and in relation to a child released to him as provided in section sixty-seven, as he would have if he were surety on the recognizance of such child.

SECTION 68A. (Amended by St. 838, Acts of 1969). *Diagnostic study by department of youth services; report and recommendations.*—A child between seven and seventeen years of age, held by the court for further examination, trial or continuance, or for indictment and trial under the provisions of sections seventy-three to eighty-three, inclusive, or to prosecute an appeal to the superior court, may at the discretion of the court be referred to the department of youth services, any court clinic, or the department of mental health, with its consent, and with the consent of the parents or guardian, for diagnostic study on an inpatient or outpatient basis; and, upon completion of such study, the department of youth services, court clinic or department of mental health, as the case may be, shall forward a report and recommendations to the court. In default of bail, any such child may be committed by the court to the department of youth services for a period not to exceed thirty days while undergoing diagnostic study. At the expiration of such period, such child shall be returned to the court, together with the report and recommendations of the department of youth services.

SECTION 68B. (Amended by St. 838, Acts of 1969). *Special foster homes; detention homes; transfer of child.*—The department of youth services may use or provide special foster homes and places of temporary custody commonly referred to as detention homes, at various places in the commonwealth which shall be completely separate from any police station, town lockup or jail, and which shall be used solely for the temporary care, custody and study of children committed to the care of the department of youth services. The commissioner of youth services may at his discretion transfer any child thus committed from any foster home or detention home to another such foster home or detention home.

Section 68C. (Amended by St. 838, Acts of 1969). *Diagnostic services by department of youth services.*—The department of youth services shall maintain and provide diagnostic services for the purpose of providing the diagnostic studies and making the reports and recommendations provided for under section sixty-eight A, and the department may provide offices and facilities for such diagnostic services at such places in the commonwealth as will best serve the needs of the several courts.

Section 69. *Information and reports of superintendents of schools and teachers relating to conduct of child awaiting examination or trial.*—The superintendent of the public schools in any town, any teacher therein, and any person in charge of a private school, or any teacher therein, shall furnish to any court from time to time any information and reports requested by any justice thereof relating to the attendance, conduct and standing of any pupil enrolled in such school, if said pupil is at the time awaiting examination or trial by the court or is under the supervision of the court.

Section 69A. (Amended by St. 838, Acts of 1969). *Information of probation officers, police and school authorities with respect to committed child.*—When a person has been committed to the department of youth services, the court, the probation officers, and other public and police authorities, the school authorities, and other public officials shall make available to said department all pertinent information in their possession in respect to the case.

Section 70. *Summoning of parent or guardian during case.*—At any time during the pendency of any case before a court or trial justice against a child under seventeen years of age, whether pending adjudication or during continuances or probation or after the case has been taken from the files, the court or trial justice may summon any parent or guardian of said child, or any person with whom the child resides, in the manner provided in section fifty-five.

Section 71. *Failure to appear on summons; capias.*—If any person to whom a summons is issued under the preceding section or section forty-two or fifty-five fails to appear in response to such summons, the court issuing the summons may issue a capias to compel the attendance of such person, and such capias shall be issued and served in the same manner as a capias to compel the attendance of witnesses who have failed to appear on a subpoena issued in behalf of the commonwealth in a criminal case.

Section 72. (Amended by St. 838, Acts of 1969). *Continuance of jurisdiction of courts in juvenile sessions; commitment of children over age limit to department of youth services.*—Courts, including the superior court on appeal, shall continue to have jurisdiction in their juvenile sessions over children who attain their seventeenth birthday pending adjudication of their cases, or pending hearing and determination of their appeals, or during continuances or probation, or after their cases have been placed on file; and if a child commits an offense prior to his seventeenth birthday, and is not apprehended until between his seventeenth and eighteenth birthdays, the court shall deal with such child in the same manner as if he had not attained his seventeenth birthday, and all provisions and rights applicable to a child under seventeen shall apply to such child. Nothing herein shall authorize the commitment of a child to the department of youth services after he has attained his eighteenth birthday, or give any court in its juvenile session any power or authority over a child after he has attained his eighteenth birthday.

Section 72A. (Amended by St. 308, Acts of 1964). *Proceedings upon apprehension after eighteenth birthday.*—The case of any person who commits an offense or violation prior to his seventeenth birthday, and who is not apprehended until after his eighteenth birthday, shall be heard and determined in accordance with sections fifty-three to sixty-three, inclusive. In any such case, the court, in its discretion after hearing on the complaint, either shall order that the person be discharged, if satisified that such discharge is consistent with the protection of the public; or shall order that the complaint be dismissed, if the court is of opinion that the interests of the public require that such person be tried for such offense or violation instead of being discharged.

Criminal Proceedings

Section 73. Repealed, St. 308, Act of 1964.

Section 74. (Amended by St. 787, Acts of 1967). *Limitation on criminal proceedings against children.*—Except as hereinafter provided, no criminal proceeding shall be begun against any person who prior to his seventeenth birthday commits an offense against the law of the commonwealth or who violates any city ordinance or town by-law, unless proceedings against him as a delinquent child have been begun and dismissed as required by section sixty-one or seventy-two A; provided, however, that a criminal complaint alleging violation of any provision of chapter eighty-nine or ninety, which is not punishable by imprisonment or by a fine of more than one hundred dollars, or of any city ordinance or town by-law regulating the operation of motor vehicles, may issue against a child between sixteen and seventeen years of age without first proceeding against him as a delinquent child.

SECTION 75. (Amended by St. 308, Acts of 1964). *Complaint; issuance; commitment or binding over for trial.*—If, under section sixty-one or seventy-two A, the court orders that a delinquency complaint against a person be dismissed, the court shall forthwith cause a criminal complaint to be issued against such person for the alleged offense or violation, cause such complaint to be subscribed by the complainant, and examine on oath the complainant and the witnesses produced by him; and, if the person appears to be guilty of the offense or violation, the court shall commit him or bind him over for trial in the superior court according to the usual course of criminal proceedings. Section thirty of chapter two hundred and eighteen shall apply to any such case, and section sixty-eight of this chapter shall apply to any person committed under this section for failure to recognize, pending a determination by the court that he appears to be guilty and pending final disposition in the superior court.

SECTIONS 76 to 82. Repealed, St. 308, Acts of 1964.

SECTION 83. (Amended by St. 838, Acts of 1969). *Proceedings in superior court; disposition.*—The indictment of any person bound over under section seventy-five shall be tried before the superior court in the same manner as any criminal proceeding, and upon conviction such person may be sentenced to such punishment as is provided by law for the offense, or placed on probation, with or without a suspended sentence for such period of time and under such conditions as the court may order. But, if such person has not attained his eighteenth birthday prior to a finding or plea of guilty, the superior court may, in its discretion, and in lieu of a judgment of conviction and sentence, adjudicate such person as a delinquent child, and make such disposition as may be made by a district court or the Boston juvenile court under section fifty-eight; but no person adjudicated a delinquent child under the provisions of this section shall, after he has attained his eighteenth birthday, be committed to the department of youth services or continued on probation or under the jurisdiction of the court.

SECTION 84. (Amended by St. 838, Acts of 1969). *Warrant of commitment to department of youth services.*—Whenever a person is committed to the department of youth services by a court under section fifty-six, fifty-eight or eighty-three, a warrant of commitment shall be issued in substance as follows:

THE COMMONWEALTH OF MASSACHUSETTS

(*County*) *ss.*

To the Sheriff of the County of __________ or his Deputy, or any Constable or Police Officer in said County, and to the Department of Youth Services at__________

GREETING:

Whereas, (name of person committed) of __________ in the county of__________, a boy (or girl) between seven and seventeen (or eighteen) years of age, has this day been brought before the __________ court of __________ by virtue of a summons (or warrant) issued to (against) him (or her) on the complaint of__________ of __________ in the county of __________ who therein, upon oath, says that said defendant, at __________ in the county of __________ on the __________ day of __________ in the year one thousand nine hundred and __________ was guilty of __________ as is more fully alleged in said complaint.

And after hearing all matters and things concerning the same, and all persons entitled thereto having been summoned and notified of the pendency of said complaint, as required by law, it is adjudged by said court that said defendant is delinquent and that he (or she) is of the age of __________ years and __________ months, and is a suitable subject for commitment to the custody of the department of youth services, and that his (or her) moral welfare and the good of society require that he (or she) should be sent thereto for diagnosis, treatment and training; and it is thereupon ordered by said court that said defendant stand committed to the custody of the department of youth services during his (or her) minority, or until he (or she) be discharged according to law.

You are therefore hereby required, in the name of the Commonwealth of Massachusetts, to take said defendant and him (or her) carry to the department of youth services and him (or her) deliver to the (designated officer) thereof, together with an attested copy thereof, and thereafterward forthwith to return this warrant with your doings thereon into said court.

And you, the department of youth services, are alike required to receive said defendant into your custody, and him (or her) safely keep for diagnosis, treatment, instruction and training until the expiration of said term of his (or her) minority, or he (or she) be discharged according to law.

Witness, ---------- at said ---------- this ------ day of ---------- in the year one thousand nine hundred and ----.

--*Clerk*.

A true copy.
Attest:
(*Constable of* ----------)
(*Sheriff of*--------------)

No variance from said form shall be considered material if it sufficiently appears upon the face thereof that the person is committed by the court in the exercise of the powers conferred by this chapter. The warrant may be executed by any officer qualified to serve civil or criminal process in the county where the case is heard. Accompanying the warrant, the court or magistrate shall transmit to the designated officer of the department of youth services, by the officer serving it, a statement of the substance of the complaint and testimony given in the case, and such other particulars relative to the person committed as can be ascertained.

Chapter 120

Department of Youth Services and Massachusetts Training Schools

SECTION 1. (Amended by St. 838, Acts of 1969). *Corporate status of department of youth services, holding and investing trust funds.*—The department of youth services shall be a corporation for the purpose of taking, holding and investing in trust for the commonwealth, subject to section fifteen of chapter ten, any grant or devise of land or any gift or bequest made at any time for the use of any institution of which said department has the management, government and care, and it shall succeed to and retain the rights, powers and duties formerly held or acquired by the division of youth service and by the youth service board, except as otherwise provided in said section fifteen and in this chapter.

SECTION 2. (Amended by St. 838, Acts of 1969). *Management, government and care of industrial schools; employment of expert personnel by commissioner.*—The department of youth services shall have the management, government and care of the Lyman school for boys at Westborough, the industrial school for girls at Lancaster, the industrial school for boys at Shirley, and of all other institutions, except correctional institutions of the commonwealth, supported by the commonwealth for the custody, diagnosis, care and training of delinquent or wayward children or habitual truants or habitual absentees or habitual school offenders or juvenile offenders. The department of youth services shall have control of the land and buildings of said schools. To carry out its duties under this chapter, the commissioner shall authorize the employment within the limits of the amount appropriated therefore, such medical, dental, psychiatric, psychological, social work, legal, investigative and other expert personnel, including experts in the fields of fiscal affairs, research and planning, and personnel administration and training, superintendents, field representatives, supervisory, clerical and other employees as he shall deem necessary, and shall prescribe their duties. Physicians, dentists and psychiatrists employed hereunder shall not be subject to the provisions of chapter thirty-one or section nine A of chapter thirty.

SECTION 2A. Repealed, St. 838, Acts of 1969.

SECTION 3. (Amended by St. 838, Acts of 1969). *Appointment of superintendents, chaplains and physicians.*—The commissioner of youth services shall from time to time appoint a superintendent, chaplains and a physician of each of said schools and institutions, and shall, in accordance with law appoint all other officers and employees required at said schools and institutions and shall prescribe their duties.

SECTION 4. (Amended by St. 838, Acts of 1969). *Rules and regulations; by-laws.*—The commissioner of youth services shall establish rules, regulations, and bylaws for the government of each institution and shall see that its affairs are conducted according to law and to such rules, regulations and by-laws; but the purpose thereof and of all education, employment, training, discipline, recreation and other activities carried on in the institutions shall be to restore and build up the self-respect and self-reliance of the children lodged therein and to qualify them for good citizenship and honorable employment.

SECTION 4A. Repealed, St. 838, Acts of 1969.

SECTION 5. (Amended by St. 838, Acts of 1969). *Examination and study of children committed; re-examinations; records; discharge.*—

(a) When a person has been committed to the department of youth services, it shall, under rules established by it, forthwith examine and study him and investigate all pertinent circumstances of his life and behavior.

(b) The department of youth services shall make periodic reexamination of all persons within its control. These examinations may be made as frequently as the department considers desirable, and shall be made with respect to every person at intervals not exceeding one year.

(c) The department of youth services shall keep written records of all examinations and of the conclusions based thereon, and of all orders concerning the disposition or treatment of every person subject to its control.

(d) Failure of the department of youth services to examine a person committed to its, or to reexamine him within one year of a previous examination, shall not of itself entitle the person to discharge from the control of the department, but shall entitle him to petition the committing court for an order of discharge, and the court shall discharge him unless the department upon due notice satisfies the court of the necessity for further control.

SECTION 6. (Amended by St. 838, of 1969). *Liberty under supervision; confinement; reconfinement; revocation or modification of order; discharge.*—When a person has been committed to the department of youth services, it may after an objective consideration of all available information—

(a) Permit him his liberty under supervision and upon such considerations as it believes conductive to law-abiding conduct; or—

(b) Order his confinement under such conditions as it believes best designed for the protection of the public; or—

(c) Order reconfinement or renewed release as often as conditions indicate to be desirable; or—

(d) Revoke or modify any order, except an order of final discharge, as often as conditions indicate to be desirable; or—

(e) Discharge him from control with notice to the court, except as provided in section twelve, when it is satisfied that such discharge is consistent with the protection of the public.

SECTION 6A. (Amended by St. 838, Acts of 1969). *Correction of socially harmful tendencies.*—As a means of correcting the socially harmful tendencies of a person committed to it, the department of youth services may—

(a) Require participation by him in vocational, physical, educational, and correctional training and activities.

(b) Require such modes of life and conduct as seem best adapted to fit him for return to full liberty without danger to the public.

(c) Provide such medical or psychiatric treatment as is necessary.

SECTION 7. (Amended by St. 838, Acts of 1969). *Powers and duties of superintendent.*—The superintendent of each school or other institution, with the subordinate officers, shall have general charge of and be responsible for the welfare and custody of the children lodged therein, and for carrying out the rehabilitative program prescribed by the commissioner of youth services. He shall be a constant resident at the school, and, under the direction of the commissioner of youth services, shall seek to establish relationships and to organize ways of life that will meet the moral, physical, emotional, intellectual and social needs of the children under his care as those needs would be met in adequate homes.

SECTION 8. (Amended by St. 838, Acts of 1969). ***Bond and accounts of superintendents; accounting to commissioner of department of youth services.***—**Each superintendent shall before entering upon his duties give bond to the commonwealth, with sureties approved by the governor and council, in such sum as the comptroller may prescribe, conditioned that he shall faithfully perform all his duties and account for all money received by him as superintendent. The bond shall be filed in the office of the state treasurer. Each superintendent shall have charge of all the property of the institution within the precincts thereof. He shall keep accounts of all his receipts and expenditures, and of all property intrusted to him, showing the income and expenses of the institution; and shall account to the commissioner of youth services, in such manner as said commissioner may require, for all money received by him. His books and all documents relative to the school shall at all times be open to the inspection of the commissioner of youth services.**

SECTION 9. (Amended by St. 838, Acts of 1969). *Rogers fund.*—The superintendent of the industrial school for girls, under the direction of the commissioner of youth services, shall purchase books with the income and profits and according to the terms of the donation of Henry B. Rogers.

SECTION 10. (Amended by St. 838, Acts of 1969). *Use of public or private facilities, institutions and agencies; control; inspection; acceptance and care of delinquent children; effect of placement of person in or release from institution on control by the department.*—For the purpose of carrying out its duties and effectuating the decisions of the department of youth services with respect to the classification, placement for training and treatment, transfer, release under supervision and

discharge of persons committed to the department the commissioner of youth services is authorized to make use of law enforcement, detention, supervisory, medical, educational, correctional, segregative, and other facilities, institutions and agencies, whether public or private, within the commonwealth wherever feasible, otherwise outside the commonwealth; provided however, that the department shall not transfer custody of any person who was committed to the department by a juvenile court and who is under twenty-one to a penal institution. The commissioner of youth services may enter into agreements with the appropriate private or public officials for separate care and special treatment in existing institutions of persons committed to the department.

At least twice annually, the commissioner of youth services with the assistance of the executive secretary to the advisory committee shall be responsible for convening and programing a meeting of a youth services coordinating council composed of the commissioners of public health, mental health, education, public welfare, corrections, and probation, and the commissioner of administration and finance or their designees. The youth services coordinating council shall meet for the purposes of providing for the coordination and mutual assistance in the carrying out and evaluation of all the programs relating to youth services in the commonwealth. Said council shall jointly prescribe and from time to time amend rules and recommendations of their various departments for the aforementioned purposes.

(b) Nothing herein shall be construed as giving the department of youth services control over existing facilities, institutions or agencies other than those listed in section two, or as requiring such facilities, institutions or agencies to service said department inconsistently with their functions, or with the authority of their officers, or with the laws and regulations governing their activities, or as giving said department power to make use of any private institution or agency without its consent, or to pay a private institution or agency for services which a public institution or agency is willing and able to perform.

(c) Public institutions and agencies are hereby required to accept and care for delinquent children or convicted persons sent to them by the department in the same manner as they would be required to do had such persons been committed thereto by a juvenile court, district court, superior court or probate court.

(d) The department is hereby given the right and shall be required periodically to inspect all public and all private institutions and agencies whose facilities it is using. Every institution and agency, whether public or private, is required to afford the department reasonable opportunity to examine or consult with persons committed to the department who are for the time being in the custody of the institution or agency.

(e) Placement of a person by the department in any institution or agency not operated by the department or the release of such person from such an institution or agency shall not terminate the control of the department over such person. No person placed in such institution or under such an agency may be released by the institution or agency without the approval of the department.

SECTION 11. (Amended by St. 838, Acts of 1969). *Places for detention and diagnosis; treatment and training facilities; facilities to aid persons given conditional releases; forest or farm school camps.*—When funds are available for the purpose, the commissioner of youth services may:

(a) establish and operate places for detention and diagnosis of all persons committed to the department;

(b) establish and operate additional treatment and training facilities necessary to classify and segregate and handle delinquents and juvenile offenders of different ages, habits and mental and physical condition according to their needs;

(c) establish facilities to aid persons given conditional release or discharged by the department to find employment and to lead a law-abiding existence, and shall establish, on land under the control of the department of natural resources or upon other sites approved by the commissioner of natural resources, forest or farm school camps to which children placed in the care of the department of youth services may be sent for such education and training as may be deemed best for their readjustment, the work projects of which may be assigned in farming or reforestation maintenance and development of state forests and recreational areas as may be approved by the commissioner of natural resources.

SECTION 12. (Amended by St. 838, Acts of 1969). *Parole; placing custody in home or family; agents; investigations; notice to commissioner of public welfare; resumption of care.*—The department may direct release under supervision at any time and may place children in its custody in their usual homes or in any situation or family that has been approved by the department. The commissioner of youth services may, subject to appropriation, employ agents for investigating places and for visiting and supervising children, and may provide for the maintenance, in whole or in part, of any child so placed in the charge of any person. Immediately on placing children in families or homes, the commissioner of youth services shall notify the commissioner of public welfare of the name of each child so placed and of the name and residence of the person to whose care he is entrusted. The department may at any time, until the expiration of the period of commitment, resume the care and custody of any child released under supervision. The department shall place children in families or homes of the religious belief of such children, but if this be impracticable, then due regard shall be had to the locality, and, if practicable, the home shall be such that the children shall have the opportunity to attend religious worship of their own belief.

Section 13. (Amended by St. 838, Acts of 1969). *Escape; breach of parole; arrest; detention.*—A boy or girl committed to the department and placed by it in any institution or facility, who has escaped therefrom, or who has been released on parole and broken the conditions thereof, may be arrested without a warrant by a sheriff, deputy sheriff, constable, police officer, or person employed and authorized by the department, and may be kept in custody in a suitable place and there detained until such boy or girl may be returned to the custody of the department.

Section 13A. (Amended by St. 838, Acts of 1969). *Compensation for property damage caused by inmates; notice of damage; claim; filing.*—Upon written request of the department, there shall be paid out of the state treasury, from such funds as may be available therefor, to any person determined by the attorney general to be entitled to compensation for damage to his property caused by the act of any inmate of the Lyman school for boys at Westborough, the industrial school for girls at Lancaster, the industrial school for boys at Shirley, the department of youth services reception center at Westborough or any other institution of which the board has management, government and care under the provisions of section two while escaping therefrom, such sum as the attorney general shall determine to be just and reasonable and as the governor and council shall approve; provided, that written notice of said damage and claim for compensation therefor be filed with the department within one year next after the date on which such damage occurred.

Section 14. (Amend by St. 838, Acts of 1969). *Application for new committments for insane, feeble minded and sexually psychopathic persons.*—Whenever the department finds that any person committed to it is insane or feeble minded, within the meaning of chapter one hundred and twenty-three, or a sexual psychopath, within the meaning of chapter one hundred and twenty-three A, or a potential psychotic, as defined and determined by the assistant commissioner of the bureau of clinical services, the department may make application to the proper court for a new commitment to the appropriate agency in accordance with law.

Section 15. (Amended by St. 838, Acts of 1969). *Transfers from Massachusetts reformatory and reformatory for women.*—With the consent of the department, the commissioner of correction may transfer to the care of the department any boy under seventeen sentenced to the Massachusetts reformatory, or any girl under seventeen sentenced to the reformatory for women, for such disposition as in the opinion of the department, after study, will best serve the needs of the boy or girl and best protect the interests of the public.

Section 16. (Amended by St. 838, Acts of 1969). *Discharge.*—Every person committed to the department as a wayward child or delinquent child, if not already discharged, shall be discharged when he reaches his twenty-first birthday, unless a petition is filed by the department under section seventeen. Every person committed to the department after conviction in criminal proceedings, unless already discharged, shall be discharged when such person reaches his twenty-third birthday, unless a petition is filed by the department under section seventeen.

Section 17. (Amended by St. 838, Acts of 1969). *Procedure when discharge deemed dangerous; control beyond age limit; order; application; statement of facts; review of order.*—Whenever the department is of the opinion that discharge of a person from its control at the age limit stated in section sixteen would be physically dangerous to the public because of the person's mental or physical deficiency, disorder or abnormality, the department shall make an order directing that the the person remain subject to its control beyond the period and shall make application to the committing court for a review of that order by the court. The order and application shall be made at least ninety days before the time of discharge stated in section sixteen. The application shall be accompanied by a written statement of the facts upon which the department bases its opinion that discharge from its control at the time stated would be physically dangerous to the public, but no such application shall be dismissed nor shall the order be discharged, merely because of its form or an asserted insufficiency of its allegations; every order shall be reviewed upon its merits.

SECTION 18. (Amended by St. 838, Acts of 1969). *Notice of application for review of order; hearing; appointment of counsel; court order.*—If the department applies to the court for review of an order as provided in section seventeen, the court shall notify the person whose liberty is involved, and if he or she be not sui juris, his parent or guardian (if such person can be reached and if not the court shall appoint a person to act in the place of the parent or guardian), of the application, and shall afford him an opportunity to appear in court with the aid of counsel and of process to compel attendance of witnesses and production of evidence. When he is unable to provide his own counsel, the court shall appoint counsel to represent him.

If after a full hearing the court is of opinion that discharge of the person to whom the order applies would be physically dangerous to the public because of his mental or physical deficiency, disorder, or abnormality the court shall confirm the order of the department. If the court is of opinion that discharge of the person from continued control of the department would not be physically dangerous to the public, the court shall disapprove the order of the department and shall order the person to be discharged from its control.

SECTION 19. (Amended by St. 838, Acts of 1969). *New orders if control continued; periodic applications for review; procedure.*—When an order of the department is confirmed as provided in section eighteen, the control of the department over the person shall continue, subject to the provisions of this chapter; but, unless the person is previously discharged in accordance with section six (e), the department shall, within two years after the date of such a confirmation in the case of persons committed as wayward children or delinquent children, or within five years after the date of such a confirmation in the case of persons committed after conviction in criminal proceedings, make a new order and a new application for review thereof in accordance with the provisions of section seventeen. Such orders and applications may be repeated at intervals as often as in the opinion of the department may be necessary for the protection of the public, except that the department shall have power, in order to protect other children and adolescents, to transfer the custody of any person over twenty-one years of age to the department of correction for placement in the appropriate institution.

Every person shall be discharged from the control of the department at the termination of the period stated in this section unless the department has previously acted as therein required, and shall be discharged if the court fails to confirm the order as provided in section eighteen.

SECTION 20. (Amended by St. 838, Acts of 1969). *Appeal to superior court; modification; reversal; control pending appeal.*—(a) If under the provisions of sections eighteen and nineteen the court confirms an order, the person whose liberty is involved may appeal to the superior court for a reversal or modification of the confirmation. The appeal shall be taken in the manner provided by law for appeal to the said court from judgments of an inferior court in criminal cases.

(b) After the hearing of the appeal the superior court may affirm the order of the lower court, or modify it, or reverse it and order the appellant to be discharged by the department.

(c) Pending the appeal the appellant shall remain under the control of the department.

SECTION 21. (Amended by St. 838, Acts of 1969). *Effect of commitment on application for public service; discharge; restoration of civil rights; records; inspection; consent; evidence in other proceedings.*—Commitment to the care of the department of a wayward child or delinquent child shall not operate to disqualify said child in any future examination, appointment or application for public service under the government either of the commonwealth or of any political subdivision thereof.

Whenever a person committed to the department by a court upon conviction of a crime is discharged from its control such discharge shall, when so ordered by the department, restore such person to all civil rights and shall have the effect of setting aside the conviction. The conviction of such a person shall not operate to disqualify him for any future examination, appointment or application for public service under the government either of the commonwealth or of any political subdivision thereof.

The records of commitment to the department shall be withheld from public inspection except with the consent of the department, but such records concerning any child who at the time of commitment was between seven and seventeen years of age shall be open, at all reasonable times, to the inspection of the child, his or her parent or parents, guardian or attorney, or any of them. A commitment to the department shall not be received in evidence or used in any way in any proceeding in any court except in subsequent proceedings for waywardness or delinquency against the same child, and except in imposing sentence in any criminal proceeding against the same person.

SECTION 22. (Amended by St. 838, Acts of 1969). *Inquiry into effectiveness of methods; Information; annual report; contents.* The department shall conduct continuing inquiry into the effectiveness of the treatment methods it employs in seeking the reformation of juvenile and youthful offenders. To this end the department shall obtain from the commissioner of probation all court record information on its wards compiled subsequent to their discharge from the jurisdiction of the department, and with the cooperation of the commissioner of probation tabulate and analyze these data so that they may be used to evaluate the relative merits of methods of treatment. The results of such studies shall be made available to the public in each annual report of the department. The department shall make an annual report to the governor and to the general court containing, in addition to other matters required by law, a statement of the number of persons committed to the department during the preceding fiscal year and of the disposition made of such persons and of all other persons under its supervision during said year. The report shall include such inventories as the institutions under the department's supervision are required by law to make, a statement of the condition and needs of the facilities under its supervision, and of the progress made toward an integrated rehabilitory system capable of giving the most effective individual treatment for rehabilitation. The report shall include such recommendations for legislation as the department may wish to make.

SECTION 23. (Amended by St. 838, Acts of 1969). *Power of department to act as guardians of children.*—The department may act as guardians for any boy or girl in its charge under twenty-one who has neither parent living nor guardian, with all the power and authority conferred by chapter two hundred and one, except that when a guardian is appointed, the powers herein conferred shall cease.

SECTION 23A. (Amended by St. 838, Acts of 1969). *Disposition of unclaimed money held for former ward; records.*—Annually on or before November thirtieth, the department shall pay to the state treasurer all unclaimed money held by it for the benefit of any former ward of the department whose whereabouts are then unknown to it and have been unknown for seven years subsequent to his becoming of age. At the time of so paying over any such money, the department shall certify to the comptroller the amount of such money then held for the benefit of each former ward, his full name, age, if known, and last known address, the names of his parents, if known, and such further information as it deems relevant; and said comptroller shall make and keep a record thereof.

SECTION 24. (Amended by St. 838, Acts of 1969). *Expenditure of gifts.*—The department may expend any money given for the purpose in erecting houses or other buildings on the land of the commonwealth at Lancaster, for increasing the accommodation and facilities of the industrial school, if the plans therefor are first approved by the bureau of building construction.

SECTION 25. (Amended by St. 838, Acts of 1969). *Children committed by United States courts.*—The provisions of this chapter relative to commitment to the care of the department shall extend to boys and girls committed by authority of the courts or magistrates of the United States.

SECTION 26. (Amended by St. 838, Acts of 1969). *Aiding or assisting in escape.*—Whoever aids or assists a child in the custody of the department to escape or attempt to escape shall be punished by a fine of not more than five hundred dollars or by imprisonment for not more than two years.

Chapter 123

COMMITMENT AND CARE OF DEFECTIVE DELINQUENTS

SECTION 1. *Definitions.*—The following words as used in this chapter, unless the context otherwise requires, shall have the following meanings:

"Commissioner", commissioner of mental health.

"Department", the department of mental health.

"Institution", hospital or other institution, public or private, under the general supervision of the department.

"Judge", judge or justice.

"Residence", residence or place where found.

"State hospital", state hospital, state school, state colony or other state institution under the control of the department.

"State", state, territory, or dependency of the United States.

"Mentally ill" person, for the purpose of involuntary commitment to a mental hospital or school under the provisions of this chapter, shall mean a person subject to a disease, psychosis, psychoneurosis or character disorder which renders him so deficient in judgment or emotional control that he is in danger of causing physical harm to himself or to others, or the wanton destruction of valuable property, or is likely to conduct himself in a manner which clearly violates the established laws, ordinances, conventions or morals of the community.

The terms "mentally ill" and "mental illness" shall have the same meaning as the terms "insane" and "insanity", respectively, as now or formerly used in this chapter and in rules and regulations of the department, but a finding that a person is mentally ill for purposes of commitment to a mental hospital or school shall not per se import a finding of civil incompetency or of criminal irresponsibility.

"Mentally deficient" person, a person whose intellectual functioning has been abnormally retarded, or has demonstrably failed, the deficiency being manifested by psychological signs. "Mentally deficient" shall have the same meaning as the term "feeble minded" as now or formerly used in this chapter.

Section 66. *Commitment to schools for feeble minded persons: application: certificate: order.*—Any judge of probate, within his county, upon written application, if he finds that a person residing or being within said county is a proper subject for the Walter E. Fernald state school, the Belchertown state school, the Paul A. Dever state school or the Wrentham state school, may commit him thereto by an order of commitment, directed to the superintendent thereof, made in accordance with section fifty-one, and accompanied by a certificate in accordance with section fifty-three by a physician, qualified as therein provided, that such person is a proper subject for said school, and all provisions of said section shall apply to such certificate, except that the physician's examination of the alleged feeble minded person shall have occurred within ten days of the signing and making oath to the certificate, which shall bear date not more than twenty days prior to the commitment of such person. Any justice of a district court may, in the manner and subject to the conditions imposed by the preceding sentence, commit a person, including a juvenile, residing or being within his district to any of such schools; but no person shall be so committed unless the approval of the department shall be filed with the application for his commitment. The order of commitment shall also direct the sheriff, deputy sheriff, constable, police officer, or other person to apprehend and convey the said person to the school to which he has been committed. Such order shall be void if such person shall not be received at the school named therein within sixty days after the date of such order. Unless the person sought to be committed is present at the time of the hearing, or the application is made by some one legally entitled to his custody, notice of the application and of the time and place of hearing shall be given to the person sought to be committed, and the order of commitment shall state what notice was given or the finding of facts which made notice unnecessary, and shall authorize custody of the person until he shall be discharged by order of a court or otherwise in accordance with law.

If a feeble-minded person is committed to such a school, the department shall thereafter have power, whenever advisable, to transfer him to the custody or supervision of the department; and thereafter the provisions of section sixty-six A, relative to removal, temporary release and discharge of feeble-minded persons, shall apply to such person.

Section 66A. *Commitment of feeble-minded person to custody of department: application: approval: powers of department.*—If an alleged feeble-minded person is found, upon examination by a physician qualified as provided by section fifty-three, to be a proper subject for commitment, the judge of probate for the county in which such person resides or is found may upon application commit him to the custody or supervision of the department; but no person shall be so committed unless the approval of the department shall be filed with the application for his commitment. If he is committed to the custody or supervision of the department the department shall thereafter have power, whenever advisable, to transfer him to a state school for the feebel-minded. If the alleged feebel-minded person is committed to the custody or supervision of the department of mental health, the said department may temproarily release him in the manner provided by, and subject to, the provisions of section eighty-eight, or may discharge him under section eighty-nine.

Section 100. *Commitment of persons under complaint or indictment found to be mentally ill; examination.*—If a person under complaint or indictment for any crime, or a child between seven and seventeen years of age complained of as a delinquent or wayward child, is at the time appointed for trial, hearing or sentence, or at any time prior thereto found by the court to be mentally ill or in such mental condition that his commitment to a state hospital is necessary for his proper care or observation pending a determination as to any mental illness, the court may commit him to a state hospital or to the Bridgewater state hospital under such limitations, subject to the provisions of section one hundred and five, as it may order. The court may in its discretion employ one or more experts in mental illness, or other physicians qualified as provided in section fifty-three, to examine the person or child complained of as a delinquent or wayward child, and all reasonable expenses incurred shall be audited and paid as in the case of other court expenses. A copy of the complaint or indictment and of the medical certificates attested to by the clerk shall be delivered with such person or child in accordance with section fifty-three. If recoveyed to jail or custody under section one hundred and five, he shall be held in accordance with the terms of the process by which he was originally committed or confined.

Section 113. *Commitment to department for defective delinquents.*—For the purposes of this section, the term "crimes which create a danger to life or limb" shall include crimes defined in sections thirteen through twenty-nine of chapter two humdred and sixty-five; sections one through five A, eleven through nineteen, one hundred and one, one hundred and two, and one hundred and seven of chapter two hundred and sixty-six; section thirty-four of chapter two hundred and seventy-two; and section six of chapter two hundred and seventy-four.

At any time prior to the final disposition of a case in which a defendent over the age of fifteen is charged with a crime, other than murder, the commission of which creates a danger to life or limb, a district attorney may file an application for the commitment of such offender to a department for defective delinquents, established under sections one hundred and seventeen and one hundred and twenty-four.

Upon the filing of an application for commitment to a department for defective delinquents, the court shall cause such person to be committed for not more than thirty-five days' observation in a defective delinquent department, at which time such person shall be examined by two experts appointed by the commissioner of mental health with a view to determining whether or not he is mentally defective. Within thirty-five days, and after such observation and examination, the experts so appointed shall file a written report with the clerk of the court in which the case is pending, and the report shall be accessible to the probation officer, to the district attorney, and to the defendant and his attorney.

If, after such observation and examination, such person is found not to be mentally defective, he shall be returned to the court from which he was committed for observation, with a written report of the examination, for a different disposition of the case.

If a person is found to be mentally defective, the court shall give written notice to the person, and if such person is under the age of seventeen, shall also give notice to his parents, guardian or nearest relative that a hearing is to be held for his commitment to a defective delinquent department.

If, after a hearing and examination of the record, character and personality of such person the court finds that such person has shown himself to be dangerous or shows a tendency toward becoming such, that such tendency is or may become a menace to the public, and that such person is not a proper subject for the school for the feeble minded or commitment as an insane person, the court shall make a report on the finding to the effect that the person is a defective deinquent and may commit him to a department for defective delinquents according to his age and sex, as hereinafter provided.

If a person has been committed as a defective delinquent in accordance with this section, such commitment shall be a final disposition of any criminal offense charged.

A person may appeal from the order of commitment as a defective delinquent to the superior court sitting for criminal business in the county from which he has been committed, in the manner provided by section twenty-two of chapter two hundred and twelve, but shall be held in an appropriate defective delinquent department to abide the final order of the court. If the appellant so requests, an issue or issues shall be framed and submitted to a jury in the superior court.

SECTION 115. *Certificates of psychiatrists or physicians; filing; examinations; records.*—No person shall be committed to a department for defective delinquents under section one hundred and thirteen or one hundred and fourteen or be removed thereto under section one hundred and sixteen unless the report of the department of mental health required under said sections contains a certificate by two psychiatrists who examined him that such person is mentally defective.

All persons confined on October first, nineteen hundred and forty-seven under commitment as defective delinquents as provided in this chapter shall be examined forthwith by two psychiatrists appointed by the commissioner of mental health and all reports of such examinations shall be transmitted to the commissioner of correction. In any case where such examination discloses that the person examined is not mentally defective immediate steps shall be taken by the commissioner of correction in the probate court to secure the termination of his defective delinquent status.

The psychiatrists appointed to make such examinations under this section shall have access to all records of the department of correction pertaining to the persons being examined and shall be provided by the superintendent of the institution with such necessary psychometric and psychological examinations as they may require. Any person under commitment as a defective delinquent who is examined under the above provisions and found to be insane and no longer a proper subject to remain in the department for defective delinquents shall be forthwith committed to a state hospital as an insane person and transferred to the designated state hospital upon the issue of the order of commitment by a judge of any court authorized to issue an order of commitment for insanity. While under commitment as insane, the defective deliqnuent commitment shall remain in force unless otherwise terminated by a proper judicial order.

The fees of the psychiatrists or physicians issuing such certificates or issuing certificates under section one hundred and seventeen A, or conducting examinations of defective delinquents under this section, shall be in the amount and paid in the manner provided for like service in sections three to one hundred and twelve, inclusive.

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SECTION 127. *Drug rehabilitation advisory board.*—There shall be in the division a drug rehabilitation advisory board, consisting of the commissioners of public health, correction, rehabilitation and education, the commissioner of youth services and seven experts in the field of drug dependency appointed by the governor, at least one of whom shall be a rehabilitated drug dependent person. Of the members first appointed, two shall be appointed for a term of one year, two shall be appointed for a term of two years, and three shall be appointed for a term of three years. Thereafter the governor shall appoint members to succeed those appointed members whose terms expire to serve for terms of three years. Each appointed member shall serve until his successor is appointed and has qualified. No member shall be appointed to serve more than two consecutive three-year terms. The members of the advisory board shall serve without compensation but shall be reimbursed for their expenses actually and necessarily incurred in the discharge of their duties. The governor shall annually designate the chairman of the advisory board from among its members.

The advisory board shall in its general advisory capacity assist the director in coordinating the efforts of all public agencies and private organizations and individuals within the commonwealth concerned with the prevention or treatment of drug dependency, providing for the most efficient and effective utilization of resources and facilities, and developing a comprehensive program for treatment of drug dependent persons and persons in need of immediate assistance due to the use of a dependency related drug. The advisory board shall make an annual report to the governor and a copy thereof shall be made available to the commissioner.

The commissioner shall be a member ex officio of the advisory board and in such capacity shall advise and make recommendations to the advisory board and otherwise assist the advisory board in the performance of its functions under sections one hundred and twenty-five to one hundred and forty-three, inclusive.

SECTION 128. The director shall, subject to the approval of the commissioner, prepare and submit to the governor, and from time to time amend, a comprehensive plan for the treatment in public, private, and federal facilities of drug dependent persons and persons in need of immediate assistance due to the use of a dependency related drug. The director, in developing such plan, shall consult with the advisory board, officials of appropriate departments or agencies of the federal government and the commonwealth and its political subdivisions, and private organizations and individuals with a view toward providing coordinated and integrated services on the community level. The plan shall include a detailed estimate of the cost of its implementation and of the extent to which funds, property or services may be available from the commonwealth or any of its political subdivisions, the federal government or any private source.

Chapter 123A

Care, Treatment and Rehabilitation of Sexual Offenders and Victims of Such Offenders

SECTION 1. The words "sexually dangerous person" as used in this chapter shall have the following meaning:—Any person whose misconduct in sexual matters indicates a general lack of power to control his sexual impulses, as evidenced by repetitive or compulsive behavior and either violence, or aggression by an adult against a victim under the age of sixteen years, and who as a result is likely to attach or otherwise inflict injury on the objects of his uncontrolled or uncontrollable desires.

Section 2. The commissioner of mental health shall establish and maintain, subject to the jurisdiction of the department of mental health, a treatment center, hereinafter in this chapter called the center, at a correctional institution approved by the commissioner of correction, for the care, custody, treatment and rehabilitation of persons described in section one. The commissioner of mental health shall properly staff and keep properly staffed said center, and with the consent of the commissioner of correction, may establish branches of said center at suitable correctional institutions in the commonwealth. The commissioner of mental health may also establish branches of said center at any suitable facility of the department of mental health. Any branch shall be deemed to be a part of said center for the purposes of this chapter, or for such limited purposes as the commissioner of mental health shall designate.

Section 3. Notwithstanding any other provision of law when a person is brought before a district court charged with the crime of indecent assault or indecent assault and battery, indecent assault and battery on a child under the age of fourteen, open and gross lewdness and lascivious behavior, unnatural and lascivious acts with another person or with a child under the age of sixteen, lewd wanton and lascivious behavior or indecent exposure, or an attempt to commit any such crime, the court shall, if it appears that said person is guilty of the crime and appears to be a sexually dangerous person, commit or bind over said person for trial in the superior court. In such cases the clerk of the district court shall forthwith transmit to the clerk of the superior court a copy of the complaint and of the record, the original recognizances, a list of the witnesses, a statement of the expenses and the appearance of the attorney for the defendant, if any is entered, and the report of the department of mental health as to the mental condition of the defendant if such report has been filed under the provisions of section one hundred A of chapter one hundred and twenty-three, and no other papers need be transmitted.

Section 4. Upon the determination of guilt of a person in the superior court of the crime of indecent assault or indecent assault and battery, indecent assault and battery on a child under the age of fourteen, rape, rape of a female child under sixteen, carnal knowledge and abuse of a female child under sixteen, assault with intent to commit rape, open and gross lewdness and lascivious behavior, incest, sodomy, buggery, unnatural and lascivious acts with another person or with a child under the age of sixteen, lewd, wanton and lascivious behavior or indecent exposure, or an attempt to commit any such crime, the court, may, upon its own motion or upon motion of the district attorney, prior to imposing sentence, commit him to the center or to a suitable branch thereof for a period not exceeding sixty days for the purpose of examination and diagnosis under the supervision of not less than two psychiatrists who shall, within said period, file with said court a written report of such examination and diagnosis, and their recommendations for the disposition of such person. The court shall supply to the examining psychiatrists copies of the court record, and the probation officer shall supply them with the probation record of the person committed for examination. The probation record shall contain a history as such person's previous offences and previous psychiatric examinations and such other information as may be helpful to assist such psychiatrists in making their diagnosis.

Section 5. If the report filed with the court under section four clearly indicates that such person is a sexually dangerous person, the court shall give notice to such person that a hearing will be held to determine whether or not he is a sexually dangerous person.

Upon the motion of such person or upon its own motion the court shall, if necessary to protect the rights of such person, appoint counsel for him. Such person shall be entitled to have process issued out of the court to compel the attendance of witnesses in his behalf. Upon such hearing it shall be competent to introduce evidence of the person's past criminal and psychiatric record and any other evidence that tends to indicate that he is a sexually dangerous person. Any psychiatric report filed under this chapter shall be admissible in evidence in such proceeding. The court may, in its discretion, exclude the general public from attendance at such hearing, and the proceeding shall be summarized in writing.

If the court finds upon such hearing that the person is not a sexually dangerous person, it shall proceed as provided by law upon a determination of guilt of the original offence. If the court finds that the person is a sexually dangerous person, it may, in lieu of the sentence required by law for the original offence, commit such person to the center, or a branch thereof, for an indeterminate period of a minimum of one day and a maximum of such person's natural life. The court may grant probation or suspend the commitment upon the condition that such person receive out-patient treatment and upon any other condition it might deem suitable, if the department of mental health recommends such person as a suitable subject for such out-patient treatment. The court shall forward its order to the commissioner of correction who shall thereupon transfer the person to the center, or a branch thereof, for the purpose of treatment and rehabilitation, where he shall be held until released under the provisions of section nine. Persons committed shall be subject to all laws, rules and regulations which govern inmates of the institution to which they have been committed, in so far as may be compatible with the treatment provided for by this chapter, and they shall be entitled to such rights and privileges of such inmates, in so far as may be compatible with such treatment.

SECTION 6. If a prisoner under sentence in any jail, house of correction or prison, or in the custody of the department of youth services, appears to the sheriff, keeper, master, superintendent or commissioner of youth services, who has him in custody or to the district attorney for the district in which such prisoner was sentenced to be a sexually dangerous person and in need of the care and treatment provided at the center, such officer may notify the commissioner of mental health, who shall thereupon cause such prisoner to be examined by a psychiatrist at the institution wherein he is confined. Such psychiatrist shall report the results of his examination in writing to the sheriff, keeper, master or superintendent, commissioner of youth services, or district attorney, and if such report indicates that such person may be a sexually dangerous person, the sheriff, keeper, master or superintendent, commissioner of youth services or district attorney shall thereupon transmit the report to the clerk of the courts for the county wherein such prisoner was sentenced, and if such prisoner was sentenced in Suffolk County, to the clerk of the superior court for the transaction of criminal business, together with a motion to commit such person to the center or a suitable branch thereof for examination and diagnosis for a period not exceeding sixty days. The court shall act upon such motion speedily, and if it grants the motion, shall commit such person under the provisions of section four in so far as may be applicable.

If there be no sitting of the superior court in the appropriate county at the time the motion and report is transmitted to the clerk, the clerk shall than transmit a copy of the motion and report to the chief justice of the superior court, who may act upon the motion.

If the report of the psychiatrists to the court as required under section four, indicates that such prisoner is not a sexually dangerous person, the court shall order such prisoner to be reconveyed to the institution wherein he was serving his sentence, there to be held until the termination of his sentence or until otherwise discharged.

If such report clearly indicates that such prisoner is a sexually dangerous person, the clerk shall thereupon notify the court and the district attorney, and the district attorney shall file a petition for commitment of the prisoner to the center, or a branch thereof, for treatment and rehabilitation, and he shall give notice to the prisoner or to his parents, spouse, issue, next of kin, guardian, or next friend, if it appears to the district attorney that such prisoner is incapable of conducting his contest to the report. The court may require such further notice as it deems necessary to protect the interest of the prisoner, may continue the hearing pending such notice and may appoint a guardian ad litem, if necessary. The hearing shall be conducted in the manner described in section five.

Pending the completion of such hearing, the court may order that the prisoner be retained in the custody of the superintendent of the institution in which the center, or branch thereof, is located or may commit him to the custody of a sheriff or keeper of a jail or place of detention, until such time as the matter is heard on the merits.

If the court finds that the prisoner is not a sexually dangerous person, it shall order him to be reconveyed to the institution wherein he was serving his sentence, there to be held until the termination of his sentence or until otherwise discharged. If the court finds that such prisoner is a sexually dangerous person, it shall commit him to the center, or a branch thereof, for an indeterminate period of a minimum of one day and a maximum of such person's natural life, for the purpose of treatment and rehabilitation, or it may commit such person to a mental institution or place him upon out-patient treatment, or make such other disposition upon the recommendation of the department of mental health consistent with the purpose of treatment and rehabilitation. Such prisoner shall be held in custody under sufficient security to protect society, and he shall be subject to all laws, rules and regulations which govern inmates of the institution to which he has been committed, in so far as may be compatible with the treatment provided for by this chapter, and he shall be entitled to such rights and privileges of such inmates, in so far as may be compatible with such treatment.

Section 7. Any attorney retained by or on behalf of any person committed to the center shall be admitted to visit such person at reasonable times if in the opinion of the commissioner of mental health such visit would not be injurious to such person, or if a justice of the superior court orders in writing that such visit shall be allowed. Such attorney upon request shall be entitled to receive from the clerk of the court a copy of the report of the examining psychiatrists filed under section four.

Section 8. Any person believing himself to be suffering from a physical or mental condition which may result in sexual trends dangerous to the welfare of the public may make application to the department of mental health upon forms prescribed by said department for admission to the treatment center, or a suitable branch thereof. All information pertaining to this application shall be confidential, and may not be used in any criminal proceeding or proceeding under this chapter against such person. Subject to such rules and regulations and conditions relative to payment therefor, as the commissioner shall prescribe, persons may be admitted to the center or a suitable branch thereof, for examination, diagnosis and treatment.

Section 9. Any person committed to the center for treatment and rehabilitation under section five or section six shall be eligible for parole. Such person shall be presented to the parole board for consideration for parole by the superintendent of the institution in which the center, or a branch thereof, is located, with the recommendations of the department of mental health, at least once during the first twelve months following commitment and at least once in every three-year period thereafter, and at any time upon the recommendation of two psychiatrists appointed by the commissioner of mental health that he is a fit person for parole. The parole board shall carefully and thoroughly consider the reports of the department of mental health concerning the progress of such person, as well as any other information it deems relevant, and may grant such person a parole permit to be at liberty upon such terms and conditions as it shall prescribe, including the condition be receive out-patient treatment, and any other condition that the commissioner of mental health may recommend. Such terms and conditions may be revised, altered, amended or revoked by the parole board at any time. The violation by the holder of a parole permit to be at liberty of any of the terms or conditions of such permit, or of any law of the commonwealth, shall render such permit void. The parole board may revoke such permit at any time. If such permit has become void or has been revoked the parole board may order the arrest of the holder of such permit by any officer qualified to serve civil or criminal process in any county, and the return of such holder to the center for further treatment under confinement. A person who has been so returned to the center shall be detained therein according to the terms of his original commitment.

Notwithstanding any provisions of this section, any person committed to the center, or a branch thereof, shall be entitled to have a hearing for examination and discharge once in every twelve months, upon the filing of a written petition by the committed person, his parents, spouse, issue, next of kin or any friend. A copy of said petition shall be sent to the district attorney for the district where the original proceedings were commenced and to the parole board within fourteen days after the filing thereof. Said petition shall be filed in a superior court for the district in which said person was committed, and the court shall set a date for a speedy hearing. The hearing shall be conducted in the same manner as is provided for in sections five and six. The court shall issue whatever process is necessary to assure the presence in court of the committed person and shall hear the recommendations of the department of mental health and the parole board regarding the disposition of the petition. Upon a finding by the court that such person is no longer a sexually dangerous person, the court shall order such person to be discharged from the center and he shall be released subject to such conditions, if any, as the court may impose, including the condition that such person receive out-patient treatment. If the court finds that such person still requires treatment within the center, or a branch thereof, it shall order that he continue to be held and further treated under the previous commitment. The department of mental health shall make periodic examinations every year of any person committed to the center in order to determine the progress of cure, and shall give an annual report of its findings to the district attorney for the district from which the person was committed, the court from which the person was committed, and the parole board. The psychiatrists appointed to make examinations under this section shall have access to all records of the department of correction pertaining to the person being examined. All records concerning the progress, diagnosis and examinations made by examining psychiatrists shall be available to the parole board to assist them in their determinations of parole.

SECTION 10. The commissioner of mental health may make available on a voluntary and confidential basis the facilities of the department of mental health to persons who are victims of sexual attack.

Chapter 127

Pardons

SECTION 152. *(Amended by St. 838, Acts of 1969). Pardons by Governor; annual list to general court.* In a case in which the governor is authorized by the constitution to grant a pardon, he may, with the advice and consent of the council, and upon the written petition of the petitioner, grant it, subject to such conditions, restrictions and limitations as he considers proper, and he may issue his warrant to all proper officers to carry such pardon into effect. Such warrant shall be obeyed and executed instead of the sentence originally awarded.

If a sentence of death is imposed on a child under seventeen years of age, and if, before he reaches the age of seventeen, the governor pardons such child and commits him to the care of the department of youth services, said department shall assume control over him subject to the provisions of sections seventeen to twenty, inclusive, of chapter one hundred and twenty.

Every pardon petition shall, before its presentation to the governor, be filed with the parole board, acting as the advisory board of pardons, together with all statements and signatures appended thereto, and shall thereupon become a public record. Upon receipt, the advisory board of pardons shall process each petition in accordance with the applicable provisions of section one hundred and fifty-four.

In the case of a prisoner confined under sentence for a felony, no final action or vote shall be taken on such petition until after a public hearing has been held by the council. Such hearing shall be held as soon as practicable after the filing of such petition with the council. Any action taken by the council on such petition shall be taken by a roll call vote of the members present, recording and voting as yea or nay. The presence of a quorum and the vote of the majority of all members of the council present shall be necessary for the approval or disapproval of a petition. Within three days after such vote of the council, a certified copy of such roll call shall be filed with the state secretary for public inspection.

The governor, with the advice and consent of the council, may at any time revoke any pardon if he, with such advice and consent, determines that there is a misstatement of a material fact knowingly made at the time of the filing of the written petition of the petitioner, or that such pardon was procured by fraud, concealment or misrepresentation or that any provision of this section has not been complied with, and upon such revocation the governor may issue his warrant to all proper officers to take the person so pardoned into custody and return him to the institution where he was imprisoned at the time of the granting of the pardon.

Such warrant shall be obeyed and executed by the officers to whom it is issued, and the person whose pardon has been so revoked shall have the same standing in the penal institution to which he is returned as he would have had if said pardon had not been granted, except that the time during which he has been out of said penal institution upon such pardon, shall not be counted in determining the amount of his sentence remaining to be served upon such return to such institution.

The governor shall, at the end of each calendar year, transmit to the general court, by filing with the clerk of either branch, a list of pardons granted with the advice and consent of the council during such calendar year, together with action of the advisory board of pardons concerning each such pardon, and together with a list of any revocations of pardons made under this section

The word "pardon" as used in this section shall be deemed to include any exercise of the pardoning power except a respite from sentence.

Chapter 276

SECTION 97. (Amended by St. 838, Acts of 1969). Sections eighty-three to ninety-six, inclusive, shall not authorize a probation officer to interfere with any of the duties required of the department of youth services under the law relative to juvenile offenders.

Section 100. (Amended by St. 838, Acts of 1969). Every probation officer, or the chief or senior probation officer of a court having more than one probation officer shall transmit to the commissioner of probation, in such form and at such times as he shall require, detailed reports regarding the work of probation in the court, and the commissioner of correction, the penal institutions commissioner of Boston and the county commissioners of counties other than Suffolk shall transmit to the commissioner, as aforesaid, detailed and complete records relative to all paroles and permits to be at liberty granted or issued by them, respectively, to the revoking of the same and to the length of time served on each sentence to imprisonment by each prisoner so released specifying the institution where each such sentence was served; and under the direction of the commissioner a record shall be kept of all such cases as the commissioner may require for the information of the justices and probation officers. Police officials shall co-operate with the commissioner and the probation officers in obtaining and reporting information concerning persons on probation. The information so obtained and recorded shall not be regarded as public records and shall not be open for public inspection but shall be accessible to the justices and probation officers of the courts, to the police commissioner for the city of Boston, to all chiefs of police and city marshals, and to such departments of the federal, state and local governments and such educational and charitable corporations and institutions as the commissioner may from time to time determine. The commissioner of correction and the department of youth service shall at all times give to the commissioner and the probation officers such information as may be obtained from the records concerning prisoners under sentence or who have been released.

Chapter 279

Section 2. (Amended by St. 838, Acts of 1969). In all cases the execution orders of commitment to any training school or reformatory, however named, the department of youth services, or the department of public welfare may be suspended, and such suspension continued or revoked, in the same manner and with the same effect as the execution of sentences in criminal cases.

Letter from R. R. Mellette, Jr., M.D., Director, Child Psychiatry Unit, Medical University of South Carolina, Charleston, South Carolina; and Brochure pertaining to Child Psychiatry Division, Department of Psychiatry, Medical College of South Carolina

MEDICAL UNIVERSITY OF SOUTH CAROLINA,
Charleston, S.C., March 2, 1972.

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D.C. Mental Health Association,
3000 Connecticut Avenue, N.W., Washington, D.C.

DEAR MRS. MARTIN: Enclosed is a copy of our brochure pertaining to our Inpatient Child Psychiatry Unit which has now been in operation over seven years. There are fifteen nursing personnel involved in the management of the Unit. In addition, there are two full-time Special Education teachers, Recreation Therapist and at least one Psychiatry Resident assigned to the Inpatient Service. Additionally, a child psychologist, social worker, child psychiatrist, secretary and occupational therapist extend their services on a part-time basis to the Unit. Outpatient services for children involving all treatment modalities are available. The funding for these endeavors are from private, state, and federal sources.

A separate similar Adolescent Unit, under the directorship of Dr. George Orvin, has been functioning at the Medical University approximately two years. You may want to contact him if you need additional information.

If I can be of any further assistance to you, do not hesitate to contact me.

Sincerely,

R. R. MELLETTE, JR., M.D.,
Director, Child Psychiatry Unit.

Enclosure:

CHILD PSYCHIATRY DIVISION,

DEPARTMENT OF PSYCHIATRY,

MEDICAL COLLEGE OF SOUTH CAROLINA,
80 BARRE STREET, CHARLESTON, S.C. 29401

THE CHILD PSYCHIATRY DIVISION MEDICAL COLLEGE HOSPITAL

With the activation of the Child Psychiatry Division, the State of South Carolina and the Medical College Hospital have made a major contribution in the teaching of child psychiatry and in providing care for emotionally disturbed children and their parents. The Division at the Medical College Hospital is an important link in the long chain of services which must be offered to the emotionally disturbed child and his family if he is to have a chance to become a truly effective individual. The diagnosis and treatment of an emotionally disturbed child starts with the family and the community. After inpatient treatment has been concluded by the *Child Psychiatry Division,* the treatment must be continued in the family and community or in appropriate residential centers.

PURPOSE AND PHILOSOPHY

The basic purposes of the Child Psychiatry Division are to teach psychiatric principles concerning emotionally disturbed children and their families to medical and para-medical personnel, and to provide short term psychiatric treatment. Research projects are developed within this framework.

The Child Psychiatry Division can provide only short term treatment and must depend on physicians, the Mental Health Centers and other mental health resources for the referral of patients and for the follow-up therapy of the child and family. Many emotionally disturbed children will be referred to this division with some being accepted for treatment. Careful consideration will be given to each referral; however, the Division cannot admit all referred children to the hospital.

During hospitalization, appropriate evaluation and treatment will be provided each patient. Prior to discharge, appropriate recommendations will include parental prescriptions from Recreational Therapy, Occupational Therapy, and

Special Education. The child's physician will give overall recommendations for continued therapeutic endeavors after discharge.

At times facilities which are felt to be necessary for a particular child's best management will not be available to that child in South Carolina. However, it is felt that the Child Psychiatry Division at the Medical College Hospital has the obligation to point out needs for additional desirable facilities. For this reason the ideal treatment as well as the realistically available treatment resources will be recommended.

PHYSICAL FACILITY AND STAFF

The Child Psychiatry Division is located on the East Wing of the tenth floor of the Medical College Hospital at 80 Barre Street, Charleston, South Carolina. The facility includes ten beds for child inpatient care, as well as rooms for interviewing, recreation, play therapy, special education, occupational therapy, and other necessary space for the care of patients.

The staff consists of: child psychiatrists, psychiatric residents, clinical psychologists, psychiatric social workers, recreational therapists, special education teachers, registered nurses, child care technicians, and occupational therapists.

ADMISSION TO HOSPITAL

The patient may be referred by a physician or local mental health facility. The parents of the patient will be contacted and an appointment set up for them to come to the Division for an interview. This interview will have several purposes: 1) exploring the expectation of the parents of the service to be rendered, 2) exploring tentatively the problem of the patient, 3) discussing the type of therapy offered by the Division. All available information about the patient will then be coordinated and brought before the Admissions Committee which is headed by a child psychiatrist. The referral sources will be advised as soon as possible of the Admissions Committee's decision. In the cases where children are not accepted for admission, explanations will be given to the referral source by a member of the Child Psychiatry Staff.

Emergency situations will be given special consideration with regard to the patient, family, and community circumstances involved.

THE CRITERIA FOR ADMISSION ARE

1) Children ages 4 to 13.
2) At least normal or potentially normal intelligence.
3) Primary problem of emotional origin.
4) Parents or parent substitutes willing and able to actively participate in treatment.
5) Evaluation and referral through community resources.
6) Ability to benefit from short term hospitalization.
7) Teaching value of the case.

If a child is to be admitted as an inpatient, the family will be notified of the date. Patients should arrive at the hospital Admission Office, Second Floor Center, not later than 10:00 A.M. on that day. Hospitalization and medical care insurance policies should be brought, as the hospital requires a plan for payment be made before admission. A cash deposit of the difference between estimated cost of hospitalization and estimated insurance benefits is also required. The deposit is refunded if the hospital bill is less than the estimate. One may contact the Child Psychiatry office on the Tenth Floor, telephone 723-9411, Ext. 668, if there are any questions.

COST OF CARE

Child psychiatric care is expensive. Because of factors inherent in children, such as dependency, need for direction, guidance, interest, and love of adults, they require more staff hours than adults. It is important that the basic needs of all children be met in the care of the emotionally disturbed child. The specifics of cost will be discussed with parents at the time of the decision to admit a child for inpatient treatment.

Some part-pay patients will be accepted. To be accepted in this category, the patient must meet the criteria for admission of part-pay patients as set forth by the Admission Office of the Medical College Hospital.

WHAT TO BRING

It is advisable to provide clothing and incidentials that will be sufficient for approximately a week. There is no provision for excessive quantities of clothing or clothes that require special care. Suitcases are to be taken home with parents on the day of admission.

Pajamas will not be worn during the day; therefore, other appropriate clothes will be necessary.

- 5 play outfits
- 1 Sunday outfit
- 1 coat or jacket
- 1 pair tennis shoes
- 1 pair dress shoes
- 1 pair bedroom shoes
- 6 pair socks
- 6 pair underwear
- 1 bathing suit
- 1 bathing cap (girls)

Other items to bring:

- toothbrush
- toothpaste
- hair brush
- comb
- stamps
- stationery
- pencils
- school books

LAUNDRY

Facilities are available on the floor for laundering minor articles of clothing. This will be done by a member of the staff. Responsibility for clothing requiring special attention will not be assumed. It is desirable that clothing that requires minimum care be brought. All garments and personal effects should be labeled with the child's name.

TOYS

Valuable personal possessions should be left at home since the hospital cannot be responsible for them. A child may, however, bring one or two toys. These toys may be exchanged from week to week. Large, expensive items such as radios, cameras, tape recorders, TV sets, or electric toys are not acceptable. If there is a question about a specific item, this should be discussed with the nursing staff.

FOOD

Children are not allowed to bring any type of food with them. Food may be accepted only if it is given anonymously and is to be shared with all the children on the Division. Any candy or food that is sent to a child by mail will be sent home on visiting day.

MONEY

We suggest that parents leave with the nurse $1.00 per week for their child. The nurse will handle this. A certain amount will be alloted to the child as needed. If not used, the money will be refunded. Money should be provided from time to time to replenish a child's supplies such as stamps, toothpaste, etc.

MAIL

Letters should be written to the child following admission. Mail is received on the Unit daily and is distributed to the children during their rest time. If a child is not capable of reading his letter, it is read to him.

Letters to children should be addressed to:

Tenth Floor, East
Medical College Hospital
80 Barre Street
Charleston, S.C. 29401

TELEPHONE

Children are not allowed to use the telephone and parents should not call the inpatient division. Questions concerning a child's progress will be discussed during regularly scheduled appointments.

In case of an emergency, or serious illness, parents will be contacted immediately.

VISITING

Visiting hours are on Friday afternoon and limited to a child's parents. A child may *not* have visitors the first Friday after he is admitted to the hospital.

Visiting is considered a part of the child's treatment and is determined on a weekly basis depending on the child's needs. The amount of time parents spend with their child will vary from week to week. Visiting schedules may include any of the following:

1) No visiting.
2) Limited visit in the hospital.
3) A few hours away from the hospital.
4) Visits at home varying from overnight to a full weekend.

TREATMENT PROGRAM

The Child Psychiatry Division is multi-disciplined staffed. Under the direction of a child psychiatrist, persons with training in a number of different professions work together as a team with the common goal of meeting each child's individual needs and providing the best possible patient care. The role of each of the different disciplines will be discussed in the following pages.

Upon admission of a child to the Division, diagnostic as well as treatment procedures begin. Consultation with pediatricians and other specialists are used when indicated. A number of laboratory procedures and special tests, including psychological testing, may be used. All children are given a physical examination upon admission.

Hospitalized children are seen by the child psychiatrist in group therapy at least twice each week. Several times each week children are seen in individual therapy by the resident in psychiatry who is assigned to the case.

Because the Child Psychiatry Division is family centered, the parents of the children are seen at least once each week by a member of the staff. In addition, the child psychiatrist sees the parents in groups every Friday—the mothers in one group and the fathers in another.

If any single philosophy determines the overall treatment program, it is that of a corrective living experience for the child which is aimed at eliminating those symptoms which brought him into the hospital.

LIMIT SETTING

Like others, emotionally disturbed children need structure, namely, boundaries and limits. In the treatment process, realistic limits are set and enforced. The child is aware of what is expected of him as well as what he can anticipate from the treatment environment. When the child's behavior is such that he cannot conform to this structure, he is helped by one or all of the following methods:

1) He is talked with and given a clear explanation concerning his unacceptable behavior. He is encouraged to talk about his feelings.

2) If the child's behavior remains unacceptable, he is "chaired" and encouraged to think about his behavior. During this time, he is not allowed to communicate with the other children.

3) If a child loses control to the extent that he cannot tolerate being "chaired", he is placed in the Thinking Room. Here the child is completely separated from the group in order to help him gain reasonable control.

4) At times, a child cannot tolerate the responsibilities placed upon him. In this event, he may be restricted from his usual activity for longer periods of time.

THE CHILD PSYCHIATRIST

The child psychiatrist is responsible for the coordination of the Division's multi-discipline activities which impinge on each child and his parents. By his training he is equipped to appreciate the physical, intellectual, psychological, and sociological needs of children and adults. With knowledge of individual and group dynamics he encourages optimal utilization of each staff member's professional potentials in enhancing children's health.

THE PSYCHIATRIC RESIDENT

The psychiatric resident is a qualified physician who is completing his specialty training in psychiatry with supervision. He is assigned from six months to a year to the Child Psychiatry Division. He is actively involved in diagnostic evaluations and therapy with the children and their parents.

THE CHILD PSYCHOLOGIST

The clinical child psychologist specializes in such areas as child growth and development, learning theory and the dynamics of human interaction. He is involved in the diagnostic assessment of children referred to the Child Psychiatry Division, His training enables him to assist the child and his family in psychotherapy, both individually and in groups. He also offers some in-service training to other members of the multi-discipline team.

SOCIAL WORKER

The psychiatric social worker is responsible for conducting the initial interview with the parents of any child who is referred to the Child Psychiatry Division. The aims of this first interview are: 1) to get from the parents a history of the child's problems, focusing on the presenting problem; 2) to help the parents begin to deal with their feelings about coming to the Division and what it means to them to ask for help; 3) to evaluate the strengths and weaknesses of the child's total environment—home, school, peers, etc.; 4) to determine the urgency of the case so that priorities can be set regarding psychiatric evaluation; and 5) to let the parents know what the Child Psychiatry Division can offer hospitalization on a short term basis or diagnostic evaluation.

The second responsibility of the psychiatric social worker is to serve as a link between the hospital and the communities by making the communities aware of our services and needs and by having information concerning various kinds of community resources.

The psychiatric social worker may offer direct casework services to family members of children referred to the Division.

NURSING

Nursing Service is responsible for the establishment of a therapeutic environment on the ward, and for the physical care of the children.

Nurses are directly responsible for observing interaction among the children, reporting, supervising the children, setting behavioral limits, offering guidance, and sharing information with the other staff members.

TEACHERS

The Child Psychiatry Division has two full-time special education teachers who instruct the child during hospitalization. Areas of weakness in the school work are given priority. The child is taught individually or in small groups.

Parents are requested to obtain the necessary books from the child's school. Contact with the child's former school is maintained throughout hospitalization.

In order to promote a better understanding of the child, formal and informal reports as well as achievement tests are given to the child.

OCCUPATIONAL THERAPY

The occupational therapy program provides a setting in which the child's individual needs are met through the use of an intermediate object. The projects associated with Occupational Therapy provide an outlet for the child's feelings, as well as providing the child with a realistic self concept based on his own achievement. Of equal importance is establishing meaningful peer and adult relationships through working together in a goal directed effort.

The children attend occupational therapy on a regularly scheduled basis. They are seen in groups and on an individual basis. Children are encouraged to make use of materials provided in order to develop more acceptable avenues of expressing and learning to cope with their feelings.

RECREATIONAL THERAPY

The Recreational Therapy program on the Child Psychiatry Division involves approximately twenty hours per week of structured group activity. Some of these activities are swimming, music, and outdoor sports.

The role of Recreational Therapy can be divided into three general areas:

1) Establishing a relationship with the child which can lead to learning performance skills, more comfortable patterns of peer interaction, and more acceptable ways of self expression.

2) Meeting with the parents in order to discuss the values of recreation for the child and themselves, and encouraging improvement in parental attitudes and involvement with the child in his recreational activities.

3) Offering recommendations at discharge to parents and referring agencies directed toward the child's continued opportunity in recreational pursuits.

South Carolina Legislative Code authorizing the establishment of William S. Hall Psychiatric Institute, Columbia, South Carolina. The following legislation provided for the creation of the William S. Hall Psychiatric Institute. Under the Direction of the Mental Health Commission of South Carolina this facility provides residential treatment for adolescents (12 to 18 years of age—14 at a time); day treatment with special education for children (6 to 12 years of age—10 at a time); and, out-patient treatment (ages 0 to 18—100 children and their families at a time) thus treating about 4500 annually.

[First Part of Fifty-fourth Volume of Statutes at Large (The Acts and Joint Resolutions of 1966 will Constitute the Second Part)]

ACTS AND JOINT RESOLUTIONS OF THE GENERAL ASSEMBLY OF THE STATE OF SOUTH CAROLINA, REGULAR SESSION OF 1965

(Printed under direction of Lewie Griffith Merritt, code commissioner)

SECTION 9. Time effective.—This act shall take effect upon approval by the Governor.

Approved the 1st day of June, 1965.

No. 342

An Act To Amend Section 32-931, Code Of Laws Of South Carolina, 1962, As Amended, Relating To State Mental Health Facilities; And To Amend The Code By Adding Section 32-977, So As To Make Special Provision For The William S. Hall Psychiatric Institute.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 32-931 amended—Item (2) added—mental health facilities.—Section 32-931, Code of Laws of South Carolina, 1962, as amended, is further amended by adding a new item to be designated as Item (2) to read as follows and by renumbering the remaining items.

"(2) The William S. Hall Psychiatric Institute at Columbia shall be maintained as a teaching hospital for the primary purposes of training mental health personnel and psychiatric research, in connection with the general purposes described in this section;"

When amended the section shall read as follows:

"Section 32-931. The following facilities shall continue in existence and shall be maintained for the following purposes:

(1) The South Carolina State Hospital at Columbia and Palmetto State Hospital at State Park shall be maintained for the care and treatment of persons who are mentally ill and those persons accused of crime who have been admitted to the hospital in accordance with the provisions of Section 32-969;

(2) The William S. Hall Psychiatric Institute at Columbia shall be maintained as a teaching hospital for the primary purposes of training mental health personnel and psychiatric research, in connection with the general purposes described in this section;

(3) Pineland, Richland County, shall be maintained as a training school and hospital for the care, treatment and training of persons who are mentally deficient or emotionally disturbed and such other persons under sixteen years of age who may be admitted upon approval of the Commission for the purpose of examination, adjustment, treatment or training; and

(4) The mental health clinics shall be maintained for the diagnosis, treatment and prevention of mental illness."

SECTION 2. Section 32-977 added—Commission may establish special admission procedures for a psychiatric institute.—The Code of Laws of South Carolina, 1961, is amended by adding Section 32-977 to read as follows:

"Section 32-977. The Mental Health Commission may establish special admission procedures for a psychiatric institute to be maintained primarily for the purposes of training and research. Admissions to the institute shall be based upon the needs of the institute and shall be controlled by its superintendent. In addition to the admission procedures set forth in this chapter, the institute may utilize informal admission, a procedure similar to that followed by general hospitals and which does not involve a formal application or medical certificate. Patients so admitted will be free to leave at any time during the institute's normal business hours. This procedure will be used, when indicated, for certain referrals from mental health clinics and centers. It will also be available to patients referred by private physicians for highly specialized diagnostic or treatment procedures which are not available elsewhere in the State. In addition to the mentally ill, persons suffering from neurological disorders will be eligible for admission to the institute.

For the purpose of informal admission to the institute, 'mentally ill person' shall mean a person afflicted with a mental disease, alcoholism and drug addiction as such excluded, to such an extent that he requires diagnostic evaluation, care and treatment for this condition."

SECTION 3.—Time effective.—This act shall take effect upon approval by the Governor.

Approved the 1st day of June, 1965.

Brochures of William S. Hall Psychiatric Institute, Columbia, South Carolina

Residency Programs in Psychiatry

(William S. Hall Psychiatric Institute, Columbia, South Carolina)

INTRODUCTION

In May, 1965, the State Legislature designated the William S. Hall Psychiatric Institute "a teaching hospital for the primary purpose of training mental health personnel and psychiatric research."

Physically the Institute occupies an ultramodern hospital-cottage complex that provides an unusual combination of beauty and function incorporating the latest concepts in mental health architecture and design. The Institute received full accreditation in June, 1968, from the Joint Commission on Accreditation of Hospitals and is a member of the South Carolina Hospital Association and the American Hospital Association.

Historically, the psychiatric residency program resulted from the recognition by authorities in the mental health field and state government of a crisis confronting the state in the procurement of mental health professionals. The psychiatric residency program was initiated in 1961 under the auspices of the South Carolina State Hospital and has remained in continuous operation since that time. The official transfer of the residency and other training programs to the Institute was effected in 1968. The program is fully approved for three years of training in general psychiatry by the Council of Medical Education of the American Medical Association and the American Board of Psychiatry and Neurology.

The fellowship in child psychiatry in the Institute was initiated July 1, 1969, following a survey and provisional approval of the program by the American Board of Psychiatry and Neurology and the Committee on Certification in Child Psychiatry.

In addition to the general psychiatry residency program and the child psychiatry fellowship program the Institute conducts programs in continuing education, clinical pastoral training, clinical psychology internship, occupational therapy internship, placement for graduate social work students, and psychiatric affiliation for student nurses from diploma and baccalaureate programs in the state.

The Institute has initiated a semiannual journal, "The Psychiatric Forum," devoted to the publication of articles by outstanding authors on subjects pertinent to mental health.

Future projections include continued expansion of existing clinical areas and the activation of other teaching areas to include geriatric psychiatry, psychosomatic medicine, inpatient child and adolescent units, a partial-care clinic, and a seizure clinic. A histologic and chemical analysis laboratory is in the early stages of development. Architectural plans have been approved; and funds are available from the Ensor Research Foundation.

The Department of Mental Health, recognizing its responsibility to meet the mental health needs of the state, is fully committed to the continued development of training and research programs of excellent quality providing trained professional personnel in the areas of nervous and mental disease.

PSYCHIATRIC RESIDENCY TRAINING PROGRAM

The training programs in general and child psychiatry are organized and administered by the William S. Hall Psychiatric Institute which is a component of the South Carolina Department of Mental Health. Other facilities of the Department which may be used to augment these programs include:

1. Fourteen comprehensive mental health centers and clinics
2. The South Carolina State Hospital
3. Crafts-Farrow State Hospital

Affiliate institutions include:

1. The Medical University of South Carolina
2. Columbia Hospital of Richland County
3. Veterans Administration Hospital of Columbia
4. The University of South Carolina
5. Richland County Juvenile-Domestic Relations Court
6. Pineland, A State Training School and Hospital
7. The State Board of Health Laboratories

OBJECTIVE OF THE PROGRAM

The objective is to provide a comprehensive training program in psychiatry, the goals of which are

1. To select competent, qualified, and motivated physicians who earnestly desire knowledge and skill in the field of psychiatry

2. To provide resident psychiatrists with a comprehensive and integrated eclectic training program which will enable them to reach a high level of professional competence

3. To train specialists in the area of human behavior and its maladaptations who are able to contribute to the well-being of the ill, to the advancement of knowledge, and to the education of subsequent generations.

PHILOSOPHY AND METHODS OF TRAINING

The philosophy of the program is founded upon the belief that human behavior is a dynamic process that is causally determined within each individual. These dynamic influences are reflected in all human institutions beginning with the fundamental family unit and progressing through the local community to encompass societies and cultures. A competence to deal with malfunctions of human behavior at all levels must be based then upon knowledge of these underlying dynamic processes as well as the biological media in which they operate. The increase in knowledge in recent years seems to have pointed psychiatric training toward an approach which attempts to correlate and integrate material from all influences on human development. It is therefore thought that present-day psychiatric training should emphasize the broad scope of the discipline and should be designed to stimulate inquiry while acknowledging the attendant anxieties. The process of scientific inquiry coupled with the assurance that comes with accomplishment can result in the motivation and courage to look still further into the unknown.

The program must maintain a strong academic orientation and impress the resident with a historical and current appreciation of his field as well as a keen anticipation of its future potentialities. The major techniques for the diagnosis and treatment of mental illness and social maladaptation in the various levels of society—individual, family, community—must be thoroughly pursued and mastered in both didactic and clinical spheres.

The program must encompass the expanding horizons of the promotion of mental health and the prevention of illness with strong emphasis on the contribution to be made by the community and its agencies. The interdisciplinary approach which embraces the allied professional disciplines and presently offers the best hope for coping with the magnitude of the problem must be woven into the fabric of the training program.

The uniqueness of this program stems from its position between the circumscribed training of the medical center and the less organized and less comprehensive programs in a typical state hospital. The program's being within the Department of Mental Health is especially advantageous because the mental health clinics and centers of the state are resources for training in community psychiatry. Strong emphasis on family and group interactions is inescapable.

Another significant uniqueness is the avowed purpose of integrating human biologic and dynamic processes. Research in the biologic and psychologic areas, both basic and applied, will be actively fostered. The availability of large and varied patient populations in the nearby state hospitals increases research potentialities. The availability of a full scope of multidisciplinary services offers unusual opportunities for a broad and varied learning experience.

APPOINTMENT OF RESIDENTS

Applications

Application for training in psychiatry should be submitted as early as possible before the proposed starting date. The academic year begins on July 1, and ends on the following June 30. Consideration will be given to late applications with July 1 and January 1 the preferred commencement dates.

Criteria for Acceptance

1. Graduation from an approved medical school
2. Successful completion of an approved internship
3. Evidence of good character and reputation in references from at least two physicians
4. Acceptable applicant interviews with members of the faculty in most cases
5. Permanent ECFMG certificate for foreign medical graduates

Appointments

Residents are appointed on a yearly basis. Every resident is reasonably assured of yearly reappointment until the completion of a full three-year residency unless individual considerations by members of the faculty warrant recommendations to the contrary. The resident receives a paid vacation of ten work days and fifteen days of sick leave annually. There are also certain state and national holidays when there is no conflict with the needs of the training program. A grant has been approved for housing for residents; and apartments will be constructed.

Stipends

Residents' stipends are as follows: first year, $11,358; second year, $12,496; third year, $13,633; fourth year, $14,995; fifth year, $16,202. Stipends for residents receiving grants under the National Institute of Mental Health program for general practitioners are $12,000 with additional allowances available for dependents.

FACILITIES

The William S. Hall Psychiatric Institute

The William S. Hall Psychiatric Institute is academically oriented with a full-time, well-qualified teaching staff which functions within an atmosphere and organization geared to meet the primary goals of training and research. The physical plant is an ultramodern 200-bed facility consisting of a main building with four in-patient wards, professional library, offices, classrooms and other facilities, and four patient cottages.

The full-time Institute teaching staff presently consists of nine general psychiatrists, three child psychiatrists, and two neurologists. Allied professional disciplines including nursing, clinical psychology, social work, chaplaincy, occupational and recreational therapies are all staffed with qualified professionals.

Admission policies of the Institute are designed to provide a wide range of diagnostic and treatment cases. Patients are available from several sources including referrals from community mental health clinics, private resources, and pre-screened state hospital admissions.

Mental health clinics and centers

The fourteen mental health clinics and centers providing primarily outpatient diagnostic services, treatment, and consultation to community agencies are currently in operation throughout the state. Six of these clinics, located in major metropolitan areas, have expanded their services to meet the requirements for a comprehensive mental health center. These clinics and centers are funded from local, state, and federal sources and provide important resources for training in the many important facets of community psychiatry. The Columbia Area Mental Health Center occupies one cottage of the Institute complex.

The South Carolina State Hospital

The South Carolina State Hospital is a 2,700-bed institution located in the heart of the city of Columbia. In April, 1964, it became the first state mental hospital in the southeast to be accredited by the Joint Commission on Accreditation of Hospitals. The hospital functions as a comprehensive facility geared to deal with the full scope of mental illness for patients under 65 years of age. The State Hospital admits and intensively treats a wide variety of mental illnesses. Recent extensive renovations have provided modern receiving and diagnostic facilities. Up-to-date diagnostic and treatment methods, including the interdisciplinary team approach, are used. The allied professional disciplines contribute extensively to the treatment programs. The hospital also serves those chronically ill patients whose better prognosis indicates the use of intensive remotivation techniques.

Crafts-Farrow State Hospital

This is the other major public mental hospital of the state. This facility, accredited by the Joint Commission on Accreditation of Hospitals in 1969, accommodates approximately 2,700 geriatric and long-term chronic cases. Psychiatric patients who are 65 years of age and older are admitted to this facility located only six miles from the Institute. It provides an important resource to the resident for training and research in the rapidly expanding area of geriatric psychiatry.

Medical University of South Carolina

The Medical University of South Carolina has been informally affiliated with the residency training program since its inception. Medical University faculty members continue to instruct regularly in the basic and clinical areas related to psychiatry and neurology. A formal agreement of affiliation has geen drawn by the two institutions insuring continued close cooperation. Some members of the Institute staff have clinical appointments at the Medical University and teach there regularly. All students at the Medical University complete a two-day tour of the Institute and state hospitals during the senior year. Approved externships in psychiatry at the Institute have been made available to interested senior students during elective periods.

Columbia Hospital of Richland County

This 530-bed general hospital is located within the city of Columbia. It is approved for internships and residencies in most of the specialties. The hospital maintains a full-time Director of Medical Education who cooperates closely with the residency training program in order to provide consultation experience with general hospital patients. Consultations are done under the supervision of private psychiatrists on the staff of the Columbia Hospital who are also teaching consultants to the residency training program.

A twenty-million-dollar bond issue has been approved by the electorate of Richland County; and construction of a new general hospital in underway. The ultramodern 600-bed facility is being built on a site located only one block from the Institute.

Veterans Administration Hospital

This 410-bed hospital is located in the city of Columbia approximately 4½ miles from the South Carolina State Capitol. The hospital is equipped with modern facilities and services including a complete rehabilitation service, pulmonary function laboratory, radioisotope service, 72-bed nursing care unit and a medical library. The hospital is administratively responsible for the operation of an out-patient clinic which is located in the regional office in downtown Columbia. In addition to routine outpatient treatments, the clinic also operates a mental hygiene clinic and orthopedic brace shop which serves as a prosthesis center for this location.

The University of South Carolina

This state university with over 14,000 students is located within the city of Columbia and provides affiliation with the residency training program in several areas, both on departmental and individual levels. Opportunity exists for University staff appointments for Institute personnel, as well as appointments for University faculty to the Institute staff for participation in its programs. There is active participation by faculty members from psychology, law, social work and sociology-anthropology.

Richland County Juvenile-Domestic Relations Court

The third-year psychiatric resident and the fellow in child psychiatry spend one-half day each week working with the personnel of this community agency in the county court house. They evaluate clients referred to the court, offer an interpretation, and make suggestions for therapy when indicated.

Pineland—A State Training School and Hospital

This school for the mentally retarded has a patient population in excess of 475. It is available for utilization in the general and child psychiatry training programs. Pineland is a component of the South Carolina Commission on Mental Retardation.

South Carolina State Board of Health Laboratories

Through mutual interagency cooperation, the staff of the Institute has access to the extensive clinical and research laboratory facilities of the J. Marion Sims Building, located adjacent to the Institute. Biochemical, cytologic, microbiologic and viral laboratory services are available. Joint research projects are encouraged.

INSTITUTE FACULTY

1.	Alexander G. Donald, M.D	Psychiatry
2.	Joe E. Freed, M.D	Psychiatry
3.	R. Buckland Thomas, M.D	Psychiatry
4.	James B. Galloway, M.D	Psychiatry
5.	Lucius C. Pressley, M.D	Psychiatry
6.	David H. Fuller, M.D	Psychiatry
7.	D. Devon Pollard, M.D	Psychiatry
8.	Russell M. Pantano, M.D	Psychiatry
9.	Charles H. Ham, Jr., M.D	Psychiatry
10.	Robert E. Bell, Jr., M.D	Child Psychiatry
11.	Robert C. Schnackenberg, M.D	Child Psychiatry
12.	William B. Hilbun, M.D	Child Psychiatry
13.	Charles N. Still, M.D	Neurology
14.	Caroline B. Swanton, M.D	Neurology
15.	William Rothstein, Ph. D	Clinical Psychology
16.	Jerry R. Adams, Ph. D	Clinical Psychology
17.	George R. Holmes, Ph. D	Clinical Psychology
18.	Orvin S. Nesje, A.C.S.W	Social Work
19.	John R. Higgins, A.C.S.W	Social Work
20.	Betty Sue Gandy, A.C.S.W	Social Work
21.	Harriett Ann Therrell, M.S.W	Social Work
22.	Carson C. Good, M.S.W	Social Work
23.	Lillian Herman, M.S.W	Social Work
24.	Judith A. Strauch, M.S.W	Social Work
25.	Dorothy J. Warren, M.S.W	Social Work
26.	Patricia O. Nakaji, O.T.R	Occupational Therapy
27.	June B. Jackson. O.T.R	Occupational Therapy
28.	Thomas A. Summers, B.D	Chaplaincy
29.	Lilyan R. Klein, B.S.N	Nursing Education
30.	Larice S. Brown, R.N	Inpatient Nursing Supervisor
31.	Howard West, B.S	Recreational Therapy

TEACHING CONSULTANTS

1.	Oscar Sachs, M.D	Psychiatry
2.	Sanford Oxenhorn, M.D	Psychiatry
3.	George E. Gross, M.D	Psychiatry
4.	R. Layton McCurdy, M.D	Psychiatry
5.	Rufus E. Medlin, M.D	Psychiatry
6.	Raymond E. Ackerman, M.D	Psychiatry
7.	Robert M. Prince, M.D	Psychiatry
8.	William S. Hall, M.D	Psychiatry
9.	Karl V. Doskocil, M.D	Psychiatry
10.	O. Rhett Talbert, M.D	Neurology
11.	Gilbert F. Young, M.D	Child Neurology
12.	Donald Hiers, M.D	Neuropathology
13.	Hiram B. Curry, M.D	Neurology
14.	Joseph W. Taber, Jr., M.D	Neurology
15.	R. Ramsey Mellette, Jr., M.D	Child Psychiatry
16.	Donald K. Freeman, M.D	Child Psychiatry
17.	Ingeborg H. Kruer, M.D	Child Psychiatry
18.	Paul L. Adams, M.D	Child Psychiatry
19.	W. William Ledyard, M.D	Neurosurgery
20.	B. Daniel Paysinger, M.D	Neurosurgery
21.	William H. Bridgers, M.D	Neurosurgery
22.	Robert V. Heckel, Ph. D	Clinical Psychology
23.	Roger W. Black, Ph. D	Clinical Psychology
24.	Harry H. Turney-High, Ph. D	Anthropology
25.	Thomas Smith, Ph. D	Sociology
26.	Webster Myers, Jr., L.L.M	Law
27.	Ralph C. McCullough, II, J.D	Law

RESIDENTS AND FELLOWS—1969–70

Roland E. Bieren, M.D., Chief Resident

George L. Nichols, M.D.
Robert C. Hutchins, M.D.
Patricia L. Adkings, M.D.
J. Michael Foxworth, M.D.
Eugenio F. Casanovas, M.D.
Michel P. Gingras, M.D.
Marvin K. Ballard, Jr., M.D.
James C. Rice, M.D.

THE TRAINING PROGRAM

Foreword

In 1965 the entire educational, training, and research program of the South Carolina Department of Mental Health was reviewed; and the conclusion was reached that a separate institution should be created to pursue these specialized tasks. Later in the year the General Assembly amended the laws of South Carolina pertaining to mental illness and health to make special provision for the William S. Hall Psychiatric Institute. This amendment states, "The William S. Hall Psychiatric Institute at Columbia shall be maintained as a teaching hospital for the primary purpose of training mental health personnel and psychiatric research."

After a period of planning and initial recruitment of staff, the Institute opened outpatient clinics in adult psychiatry, child psychiatry, and neurology. The first psychiatric inpatient was admitted on September 26, 1966. A neurology inpatient ward was opened in January, 1968. The Institute was accredited for clinical pastoral education in 1967. An internship program for clinical psychologists was started in February, 1968. An internship for occupational therapists has been approved. The nursing education program for the two diploma schools of nursing in the state was transferred to the Institute in October, 1968. Recognizing the need for continuing education, a director for this program was recruited in December, 1968. Three seminars a year are planned for general physicians. Basic courses in psychiatry and neurology are offered to physicians interested in developing special skills in these areas. Externships and medical clerkships for medical students provide a clinical experience with psychiatric and neurologic patients.

Admissions to the Institute are based upon training and research needs and are controlled by its director. In addition to the mentally ill, persons suffering from neurological disorders are eligible for admission. Four inpatient wards are in operation with a total bed capacity of 88. Three of the wards are for psychiatric patients and one for neurologic patients. Each ward has a bed capacity of 22. Medical, surgical, clinical laboratory, and radiological services are provided for

Institute patients in the Byrnes Clinical Center of the South Carolina State Hospital by its attending staff and medical consultants as needed. This center is fully accredited by the Joint Commission on Accreditation of Hospitals.

The outpatient clinic facilities have greatly expanded in adult psychiatry, child psychiatry, and neurology. An active affiliation is maintained with the local Veterans Administration Hospital and the Columbia Hospital for consultative services on non-pyschiatric general hospital patients during the third year. Through affiliations with the South Carolina State and Crafts-Farrow hospitals the resident gains experience with geriatric patients, the chronically ill, and forensic psychiatry. Affiliation with the Columbia Area Mental Health Center provides an excellent training experience in community psychiatry. Affiliations with the Medical University of South Carolina and the University of South Carolina make possible instruction in basic medical sciences, sociology, psychology, anthropology, and law. Adequate facilities, patients, and staff are available to support six residents in each of the three years of training

Patients may be self-referred or referred by private physicians. The fourteen mental health centers and clinics which are an integral part of the Department of Mental Health refer many patients. The two state hospitals within the Department, with approximately 5,400 patients (over 4,000 admissions per year), are also a source of patients who may be selected for Institute admission because of a particular evaluation or treatment problem.

Training Program Outlined

First-year program.—The major assignment during the first year is the Inpatient Service. During this time the resident is directly responsible for care of patients assigned to him under the supervision of a teaching psychiatrist who is in charge of the ward. The average patient load is approximately ten active cases.

During July and August, prior to the start of the formal didactic teaching program in September, the resident is provided a structured orientation. This includes a general orientation to the facilities of the Institute, other components of the Department of Mental Health and affiliated institutions. Additionally, there are approximately twenty-four scheduled hours of instruction on topics which include ward organization, functions of allied professional disciplines and introductory clincial material. Individual supervision is also begun.

While the resident is developing a firm foundation in basic psychiatry and becoming increasingly familiar with diagnostic and treatment procedures on the Inpatient Service, he is also introduced to the Outpatient Clinic. Residents are encouraged to select one or two patients for supervised outpatient therapy. Contact with clinical neurology begins with an introductory series of clinical demonstrations to familiarize the resident with the neurological examination. He also attends the neurology clinical conferences and clinicopathological conferences. In addition, neurological supervision of individual cases is available.

The resident is supervised in all of his activities by members of the faculty. He works in a setting which provides training for other allied professionals; and he is familiarized with interdisciplinary techniques and the team approach.

The faculty, assisted by a consulting staff and guest lectures, provides didactic course work in the form of lectures and seminars during the first year. The curriculum has been designed to support the clinical experience of the resident and to lay the groundwork for future assignments. An attempt has been made to harmonize the three years of the program to provide a logical progression of learning with correlation between major areas.

Instruction in basic sciences is provided chiefly by staff members of the Medical University of South Carolina who meet regularly with the resident staff throughout the year.

Grand Rounds, a literature seminar, clinical case conferences, and guest speakers round out the schedule to provide the depth and variety of learning experience necessary for a well-balanced program.

Second-year program.—The second year consists of two major assignments. One is for a period of nine months in the Outpatient Psychiatry Clinic of the Institute. Approximately three-quarters of the resident's time is concerned with adult outpatients. The remaining one-quarter of his time is devoted to outpatient child psychiatry.

In the outpatient clinics the resident becomes proficient in the evaluation, treatment and disposition of psychiatric outpatients. He continues therapy with selected outpatients from the first year and acquires additional ones. Much emphasis is placed on the interdisciplinary team approach, particularly in child psychiatry which focuses upon the concepts of family dynamics and pathology. Aspects of community psychiatry and work with community agencies are emphasized in both the adult and the child psychiatry clinics and in special assignments to the Columbia Area Mental Health Center. The Adult Psychiatric Outpatient Clinic places strong emphasis on analytically-oriented individual and group psychotherapies.

The other major assignment of three months is on the Neurology Service. This period involves active participation in the neurology teaching program under two full-time staff neurologists, five consultants in neurology, and three consultants in neurosurgery. The resident has responsibilities on the neurology teaching ward, in the Neurology Clinic and in the Neurology Consultation Service. He receives further intensive supervised experience in the diagnosis and treatment of the patients suffering from diseases of the nervous system. During this period, he is expected to conduct at least one neurology seminar and to assist the senior staff at neurology conferences, ward rounds, and neuropathology sessions.

The didactic Advanced Curriculum series of seminars of the second year is geared to support and augment the resident's clinical experiences and expanding knowledge and abilities. Clinically-oriented case conferences and seminars become more frequent in the curriculum during the second year. Study in the basic sciences continues.

Third-year program.—The core curricula for the first two years have provided the resident with a basic experience in the essentials of psychiatric knowledge and practice. The third year provides an opportunity for the resident to extend his experience beyond minimum requirements in the major areas of previous study. Flexibility to permit reasonable pursuit of special interests that the resident may have developed is also encouraged.

The third year consists of four quarters which, along with the single quarter in the second year, provides for five assignments of three months each. Three of these are taken by major requirements leaving two electives. All residents are expected to continue to carry several long-term cases in psychotherapy during this time.

One three-month period consists of a full-time assignment to the Child Psychiatry Service of the William S. Hall Psychiatric Institute. Here the resident is provided sufficient supervised clinical experience with children and instruction to broaden his understanding of the biology of human growth and development and the maturational process as influenced by the family and the socio-cultural milieu in which these dynamic processes take place. He is oriented to the essential components of elementary psychotherapy with children and child-centered psychotherapy with parents. The interdisciplinary team approach is extensively utilized, and strong emphasis is placed on cooperative efforts with community agencies.

Another major three-month assignment provides the resident with clinical responsibilities on the Forensic Unit and on the Remotivation and Geriatric services of the state hospitals. He learns something of the special problems and treatment techniques which are involved with chronic hospitalized and elderly patients during this period. Along with case assignments (three) on the Forensic Unit, the resident acts as a consultant to the Richland County Juvenile-Domestic Relations Court one-half day a week.

The two remaining three-month blocks are designated as electives. Every effort is made to fit this time to the individual needs and interests of the resident. Elective assignments are made only after evaluation of the individual resident's needs and abilities by the faculty committee. Electives may be chosen in community psychiatry, neurology, child psychiatry, adult outpatient, geriatric psychiatry, or research.

The adjacent Columbia Area Mental Health Center is available for an elective in community psychiatry with all five services of a comprehensive center provided including emergency psychiatric care. The center serves an area of 350,000 population. The resident on the elective in community psychiatry may spend some time in several other community mental health centers of the state to learn of their philosophy of operation and services offered. The resident is expected to participate individually or collaboratively with a faculty member on some research project during his training period.

Throughout the entire third year the resident handles, by rotation, consultation requests on non-psychiatric general hospital patients in the Columbia Hospital and the local Veterans Administration Hospital. Supervision in the general hospital is provided by private psychiatrists; and supervision at the Veterans Administration Hospital is provided by a staff psychiatrist of the Veterans Administration and by the Institute faculty.

The didactic course work in the third year continues to complement the clinical experience and to provide more advanced instruction in some areas. Training programs for medical externs, senior medical students, student nurses, and allied professional disciplines provide ample opportunity for the resident to gain valuable teaching experience.

Seminars in psychoanalytic theory and case conferences are conducted on a regular schedule by psychoanalytically-trained psychiatrists during the nine months of the academic year. These seminars and required reading are planned to provide the resident with a firm understanding of dynamic behavior. All residents and child psychiatry fellows attend these teaching sessions.

In summary, the training program is designed to integrate biological and dynamic processes and to permit, wherever possible, a longitudinal approach to enhance the depth of learning. The clinical rotations and the curriculum in each year of training have been chosen to provide a progressive integration of knowledge and experience with a gradual advancement through increasingly broader and more sophisticated activity. The classical block system is only loosely adhered to, with emphasis placed on early contact with major areas of psychiatric endeavor and subsequently extended to more advanced experience. Didactic material complements clinical experience and attempts to anticipate it when possible. Seminar format, which encourages individual participation, takes precedence over lecture presentation.

PSYCHIATRIC RESIDENCY PROGRAM

FIRST YEAR

INPATIENT SERVICE – 12 months

Periodic rotation on different wards

Case load approximately ten active patients

Introductory assignments to psychiatric outpatients and clinical neurology

SECOND YEAR

ADULT PSYCHIATRIC OUTPATIENT CLINIC 9 months – ¾ time	NEUROLOGY SERVICE Block Assignment * 3 months
CHILD PSYCHIATRY SERVICE 9 months – ¼ time	

THIRD YEAR

CHILD PSYCHIATRY SERVICE Block Assignment * 3 months	FORENSIC, GERIATRIC AND REMOTIVATION SERVICES Block Assignment * 3 months	ELECTIVE Block Assignment * 3 months	ELECTIVE Block Assignment * 3 months
CONSULTATION SERVICE – 12 months			

*Block assignments must be made on an individual basis;and the order of rotation will vary.

INTRODUCTORY CURRICULUM*

I.	Orientation to Psychiatry	24 hours
II.	Seminar Series	54 hours
	1. Interview Techniques	3 hours
	2. Clinical Syndromes	6 hours
	3. Theory of Hospitalization	3 hours
	4. Milieu Therapy	4½ hours
	5. Drugs in Therapy	6 hours
	6. Other Somatic Therapies	3 hours
	7. Introduction to Clinical Psychology	3 hours
	8. Normal Personality Development	10½ hours
	9. Current Theories of Psycholdynamics	6 hours
	10. Introduction to Psychotherapy	9 hours
III.	Basic Science Seminars	36 hours
	1. Concepts of Organization and Function of the Nervous System (Neuroanatomy, Neurophysiology, Psychophysiology) (alternate years)	24 hours
	2. Molecular Aspects of the Nervous System in Health and Disease (Neurochemistry, Neuropharmacology, Psychopharmacology) (alternate years)	36 hours

ADVANCED CURRICULUM**

PART A:	alternate years
1. Psychopathological Entities of Childhood	15 hours
2. Advanced Psychotherapy	9 hours
3. Introduction to Psychosomatics	3 hours
4. Social Psychiatry and Cultural Anthropology	7½ hours
5. Group and Family Therapy	6 hours
6. Advanced Clinical Psychology	6 hours
7. Forensic Psychiatry	4½ hours
8. Molecular Aspects of the Nervous System in Health and Disease (Neurochemistry, Neuropharmacology, Psychopharmacology)	36 hours
9. Developmental and Child Nuerology	20 hours
PART B:	alternate years
1. Geriatric Psychiatry	6 hours
2. Community Psychiatry	6 hours
3. Consultative Psychiatry	6 hours
4. History of Psychiatry	7½ hours
5. Theories of Personality Development	9 hours
6. Theories of Character Disorders	6 hours
7. Theories of Neuroses	6 hours
8. Theories of Psychoses	6 hours
9. Principles of Research	3 hours
10. Advances in Nervous and Mental Disease	12 hours
11. Developmental and Child Neurology	20 hours
12. Concepts of Organization and Function of the Nervous System (Neuroanatomy, Neurophysiology, Psychophysiology)	24 hours

CONTINUOUS DURING THE THREE YEARS

1. Literature Seminar	1 hour weekly
2. Grand Rounds	1½ hours monthly
3. Seminars in Psychoanalytic Theory	42 hours
4. Guest Lecture Series	By Special Arrangement
5. Continuous Case Conference (optional for first year)	75 hours
6. Individual Case Supervision	2–3 hours weekly
7. Neurology Clinical Conferences	66 hours
8. Selected Topics in Nervous and Mental Disease	24 hours
9. Clinicopathologic Conference	12 hours
10. Demonstrations in Morbid Anatomy of the Nervous System	24 hours
11. Morphologic Basis of Nervous and Mental Disease	24 hours

*Presented to first-year residents

**Presented to second and third-year residents

GUEST LECTURE SERIES, 1968–1969

James J. Gibbs, M.D.
Child Psychiatrist
Sheppard and Enoch Pratt Hospital
Baltimore, Maryland
William E. Fann, M.D.
Department of Psychiatry
Vanderbilt University School of Medicine
Nashville, Tennessee
Carlyle Marney, A.B., Th.D., D.D.D.
Director of Interpreters House
Lake Junaluska, North Carolina
Beverley T. Mead, M.D.
Professor and Chairman
Department of Psychiatry
Creighton University School of Medicine
Omaha, Nebraska
Frank J. Ayd, Jr., M.D.
Editor International Drug Therapy Newsletter
Baltimore, Maryland
Charles D. Spielberger, Ph.D.
Professor of Psychology
Director of Clinical Training
Florida State University
Tallahassee, Florida
Paul B. McCleave, D.D.
Director, Department of Medicine and Religion
American Medical Association
Chicago, Illinois
John A. Ewing, M.D.
Chairman, Department of Psychiatry
University of North Carolina
Chapel Hill, North Carolina
Ray L. Birdwhistell, Ph.D.
Center for Advanced Studies
Stanford University
Stanford, California
Kenneth L. Artiss, M.D.
Assistant Professor of Psychiatry
Johns Hopkins University
Baltimore, Maryland
B. Lionel Truscott, M.D.
Director, Medical Stroke Program
Bowman Gray School of Medicine
Winston-Salem, North Carolina
Mathew Ross, M.D.
Associate Professor of Psychiatry
Harvard Medical School
Boston, Massachusetts
Katherine Norris, R.N., Ed. D.
Professor of Nursing
Department of Nursing
University of Kansas
Kansas City, Kansas
Lawrence C. Kolb, M.D.
President, American Psychiatric Association
New York State Psychiatric Institute
New York, New York
Joseph J. Baker, M.D.
Superintendent, Butler Hospital
Providence, Rhode Island
Thomas Lombard, L.L.B.
Special Counsel
U.S. Attorney General's Office
Washington, D.C.

Morton Birnbaum, L.L.B., M.D.
Attorney
New York, New York
Jack Weinburg, M.D.
Medical Director
Chicago Psychiatric Institute
Chicago, Illinois

CHILD PSYCHIATRY FELLOWSHIP TRAINING PROGRAM

PHILOSOPHY

Child psychiatry is regarded as a medical subspecialty designed to meet the needs of children whose development or behavior deviates from expected norms. The competent practitioner of child psychiatry must have a thorough knowledge of the biological, psychological, social and cultural factors which interact in the developing individual and influence what is or is not considered normal. In addition he must have a thorough knowledge of the variations of norms by ages in different individuals in different cultural and social settings.

The competent practitioner must be able to apply this background information to the examination of a child in various settings under varying conditions in order to arrive at an appraisal of these interacting factors. If the child's behavior does, in fact, deviate from the healthiest set of responses to these factors, which factors have influenced the behavior and what treatment is needed to prevent further deviation to enable the child to develop more appropriate and effective behavior? The appraisal must be derived in part on an intuitive basis; but it also must be derived from the application of knowledge of how the various interacting factors can impinge upon the developing personality to produce modifications of behavior.

As with any medical specialty there exists a need for more than just the purely clinical application of child psychiatry to the individual patient. The competent child psychiatrist must serve as an effective consultant not only to psychiatrists and other physicians but also to various non-medical individuals, organizations, and institutions. He must have a thorough understanding of the consultation process and must be able to apply this understanding in various settings including schools, courts, agencies, and hospitals.

Although the theoretical foundation, basic framework, and broad outlines of the specialty have been derived, much is still unknown; and new theories, new knowledge, and new concepts are needed. With the production of such new orientations clinical skills will be improved. The child psychiatrist should strive for new orientations or new integrations of concepts in order to add to the body of knowledge and improve the effectiveness of the specialty.

Administrative skill of some degree is necessary in all medical specialties; but by the nature of the clinical problems treated in child psychiatry, collaboration with other people of varying backgrounds and orientations forms the basis of effective treatment. In order to formulate the treatment goals and to direct the treatment efforts, as well as to interpret the treatment goals and efforts to various other agencies whose influences impinge on the developing personality, the child psychiatrist must develop his administrative skills to their maximum.

Teaching, whether to less highly trained physicians or to non-medical personnel, constitutes an important role for each child psychiatrist. The type of teaching may vary from simple exposition and definition of roles to efforts to nurture and develop new talent in the specialty; but much of his daily work will include some teaching. Competence and effectiveness as a teacher must be developed.

The competent child psychiatrist must fill each role: clinician (in the role of physician to the patient or as consultant), researcher, administrator, teacher. The goal of the child psychiatry fellowship program of the William S. Hall Psychiatric Institute can be summarized: to produce competent child psychiatrists.

TRAINING PROGRAM

To accomplish the goal of developing competent child psychiatrists the training program is organized to provide integrated clinical and didactic training of progressively increasing complexity. As designed, the program provides for beginning training in July; and, and, at this time, initiation of training in any other month could not be accomplished because the training experience could not be effectively integrated.

The Fellow begins his training with the observation of "normal" children in the nursery operated by the College of General Studies, University of South

Carolina. This observation alternates with observation of children of pre-school age in a kindergarten operated by the Office of Economic Opportunity ("Head-start"). Observation continues every morning (Monday through Friday for approximately six weeks when that time is rescheduled for younger, preschool patients. Supervision during this period is focused on normal developmental processes as observed in the nursery and kindergarten. The emphasis of the didactic and literature seminars during this period is focused on introductory issues to provide background for the next phase of training. During this period patients are accumulated at the rate of two per week. Grade-school or adolescent patients, who are seen late in the afternoon to avoid future conflicts with schools, are assigned first; and pre-school children who are seen in the morning hours are assigned to replace the time spent in observation. The case load is increased to a maximum of eight therapy patients per week.

After the tenth week the Fellow begins his consultation work, either with the Juvenile Court or the Department of Corrections School for Girls. This consulta- tion work continues for six months and is then shifted to the other agency. At this time, also, he becomes involved on the pediatric wards of the South Carolina State Hospital, attending daily ward rounds and treatment-planning sessions each morn- ing and devoting two hours, twice weekly, to some aspect of the therapy program. This latter area is purposely flexible: group therapy, treatment-team meetings, family therapy, or individual psychotherapy with hospitalized children comprise some of the alternatives available to the Fellow, depending on his interests and the availability of suitable patients on the ward. The emphasis of the literature and didactic seminars focuses on normal developmental processes during this period.

Early in the training program opportunity is provided to develop research interests. As the Fellow accumulates information regarding research interests. research design, and research organization, he can formulate his own project which he will carry through entirely. Adequate support for research is available in terms of patient populations, statistical analyses, laboratory facilities, and supervision.

In addition to these activities the Fellow has monthly conferences in pediatric neurology, group consultation with mental health personnel from throughout the state, clinicopathologic presentations, and Grand Rounds. He also begins his group therapy experience, initially as an observer and later as therapist of his own group.

After the tenth week he begins pediatric rounds at Pineland Training School, operated by the Department of Mental Retardation, in company with the pediatric residents from Columbia Hospital. His function on these rounds remains flexible in that he can utilize this time for observing administrative organization, pediatric illness in intellectually inadequate children, training programs and special education techniques, or group interactions in these children. He can begin the development of liaison with the pediatric residents, or begin to provide consultation regarding these children.

In January the Fellow shifts his consultation experience to the alternate agency listed above. He completes his didactic and literature seminar series on normal development and begins to learn in depth about the functions of other professionals with whom he works. He also has a series of seminars on various modalities of psychologic treatment which should help him conceptualize and integrate the clincial experiences he has just undergone. Diagnostic conferences, continuous case conference, group therapy, agency consultation, and administrative conferences are all supervised in a group. With the two hours of individual supervision weekly the resident should be able to complete the first year with a thorough understanding of healthy behavior and personality development as well as types of treatment available for modification of deviant behavior.

As he begins his second year of training the Fellow drops his contacts with the pediatric wards of the South Carolina State Hospital, with Pineland Training School, and with the Juvenile Court and the Department of Corrections. Emphasis now shifts to the pediatric ward of the general hospital where he makes daily ward rounds and begins to provide psychiatric consultation twice weekly. He also begins to observe children with chronic illnesses in the clinics where his role remains flexible to permit development of his own interests. Pediatric neurology conferences continue as well as group therapy, continuous case conference, and his research project.

His role as consultant now shifts to either the school system (6 months) or the Child Welfare Division of the Department of Public Welfare. Weekly group supervision of the consultative work continues.

The emphasis of the literature and didactic seminars focuses first on the psychotherapeutic process to integrate the experience with psychotherapy accumulated to this point and then shifts to the specific psychiatric diagnoses which are considered in depth. A brief series on special treatment modalities including psychopharmacologic agents is followed by seminars on research to help the Fellow integrate and orgainize his research project. The various symptomatic disturbances of childhood and adolescence are then discussed; and the series is concluded with review seminars covering the field of child psychiatry.

At the conclusion of the second year the Fellow should have had sufficient experience in the fundamental areas of child psychiatry to permit him to function effectively in his various roles in whatever area of practice he chooses. Hopefully, his own growth and development will have been sufficiently nurtured to enable him to apply both his own basic intuitive skills and the body of knowledge he has accumulated to help his patients behave in a more healthy and effective way and to add to the growth of the specialty of child psychiatry, as well as to the larger body of scientific endeavor.

COLUMBIA, SOUTH CAROLINA

Columbia, the capital of South Carolina, occupies the geographic and political center of the state. Estimated to have a population in excess of 100,000 and located in a metropolitan area approaching 300,000, the city provides an interesting blend of "The Old South" with the increased tempo of a modern, progressive community that reflects the enormous growth and expansion taking place throughout the state.

Columbia is a city of beautiful homes and gardens, as well as a focal point of industry, distribution, transportation and communication. The community provides numerous cultural advantages including an art center and a town theater. There are six universities and colleges located in the city, which also has a good public school system. Two daily newspapers, four television stations and a number of radio stations serve the area.

Recreational facilities include the Carolina Coliseum, a multimillion-dollar University of South Carolina facility; and Lake Murray, one of the nation's largest artificial lakes, located just outside the city provides ample opportunity for fishing, boating and a variety of water sports. The city maintains twenty-five parks and playgrounds, two municipal swimming pools and a youth center. A well-equipped state park is located less than ten miles away.

Columbia has four hospitals in addition to the South Carolina State and the Veterans hospitals. The city hospitals are served by a large and active group of private practioners who constitute a progressive medical community and maintain an active county medical society.

The climate in the area characteristically makes for mild winters and moderately hot summers; modern cooling methods now make the summer season quite pleasant. Availability of reasonable-priced housing is usually adequate and conveniently located.

Further information and/or application forms may be obtained from:

Associate Director of Research and Training
William S. Hall Psychiatric Institute
Drawer 119
Columbia, South Carolina 29202

OPPORTUNITIES IN CLINICAL PASTORAL EDUCATION

(William S. Hall Psychiatric Institute, Columbia, South Carolina)

Basic Clinical Pastoral Education: This program is the introductory unit of clinical pastoral education in the Institute. (A unit is twelve weeks in duration.) To be considered for the program, the student must have completed at least one year of theological education and must be interviewed by a qualified examiner. The seminary student normally participates in this program during the summer; however, students may enroll throughout the year should openings occur. Pastoral relationships are developed primarily within the inpatient area.

Clinical Pastoral Residency: The one-year residency program, beginning in mid-September and concluding the following August, is offered both to seminarians as an internship and to ordained clergy. It is geared not only for the student who desires to use his clinical experience for the parish ministry, but also for the student who considers functioning in a distinctive area of the ministry, such as the institutional chaplaincy, pastoral counseling, or the teaching ministry. Applicants preferably should have completed at least one unit of basic clinical pastoral education and are required to come to Columbia for screening interviews. The student functions in both inpatient and outpatient sections.

Pastoral Supervisory Training: This level offers the ordained clergyman, who desires to move towards certification as a chaplain supervisor, the opportunity to learn the art and skills of pastoral supervision. In order to qualify, the student should have completed at least a year of clincial pastoral education and must be evaluated by an appropriate regional committee prior to the training period. As a part of his training, the student supervises a unit of basic clinical pastoral education while under the supervision of a fully-certified chaplain supervisor.

Stipends and Fees

Stipends are available to students participating in the various levels of clinical pastoral education. Room and board provisions are also offered.

A tuition fee of $50.00 is required per 12 week unit of training. Students in pastoral supervisory programs do not pay this fee.

Curriculum Content

Curriculum is designed according to the program level in which the student is accepted. Among the curriculum resources are:

Training group seminars
Interdisciplinary treatment teams
Pastoral group work
Worship leadership
Pastoral visitation
Pastoral supervisory conferences
Lecture series
Closed-circuit TV
Clinical case conferences
Consultation with community clergy
Affiliated pastoral visits in other clinical institutions
Pastoral research papers
Consultation with interdisciplinary staff
Films and audio-tapes
Pastoral counseling (individuals and families)
Quarterly committee review of student's training experience

The Clinical Pastoral Education Program

The William S. Hall Psychiatric Institute is an ultramodern teaching hospital, accredited by the Association for Clinical Pastoral Education. The Center offers seminary students and clergymen experiential involvement and study in a depth ministry to persons. This multi-leveled program is an important aspect of a comprehensive theological education.

The Institute, a component of the South Carolina Department of Mental Health is a 212 bed psychiatric facility whose mission is focused on training and research in the field of mental health. The physical setting includes a large main building and four patient cottages wherein exist a variety of inpatient and outpatient areas. The professional training programs, characterized by a coordinated interdisciplinary effort, take place in these specialized clinical sections.

Academic Credit

The student who desires to apply his training at the Institute for academic credit can make application and the necessary arrangements with the seminary of his choice. These arrangements need the approval of both the seminary and the Institute's Pastoral Education Service.

Orientation Programs

In addition to the Clinical Pastoral Education Programs, the Institute offers throughout the year a variety of orientation programs to seminary students and clergymen. Some of these are: Consultation for Community Clergy, Clinical Introduction for Seminarians, and Clinical Pastoral Orientation for Community Clergy.

Columbia, South Carolina

Columbia, the capital of South Carolina, has a metropolitan population of approximately 300,000 people. The city is considered the geographical and political center of the state and possesses abundant recreational and cultural facilities. There are six universities and colleges, including the Lutheran Theological Southern Seminary in the city. The Institute is located within a few minutes of downtown Columbia.

For Further Information and Application Forms, Write:

Chief Chaplain
Pastoral Education Service
William S. Hall Psychiatric Institute
Drawer 119
Columbia, South Carolina 29202
Telephone: (803) 256-9911

WILLIAM S. HALL PSYCHIATRIC INSTITUTE, COLUMBIA, SOUTH CAROLINA

BACKGROUND

The William S. Hall Psychiatric Institute was established as a separate facility for research and training by the South Carolina State Legislature in 1965. This was the result of the South Carolina Department of Mental Health recognizing the need for such a facility to help meet the mental health manpower needs within the state.

Since conception, the Institute has evolved as an academically oriented teaching and research center as well as a facility offering complete in-patient and outpatient health care services for psychiatric and neurological problems. As a necessary part of the overall goals of the Institute, patients to whom health care services are offered must be selected by the staff. This may be done by consultation with family physicians, other referral sources or in some cases by direct interviews with those interested in such services.

AFFILIATIONS

The Hall Psychiatric Institute maintains active affiliations with other teaching, research and health care facilities. These include the Medical College of South Carolina, University of South Carolina, Columbia Hospital, Veterans Administration Hospital of Columbia, S.C., Columbia area Mental Health Center, and other health care, teaching, research and social agencies. Teaching appointments are held by the Institute faculty members in other such facilities, and these other agencies offer similar consultative and teaching services to the Hall Institute. Additionally, frequent guest lectures come to the Institute who are recognized authorities in their fields. It is part of the philosophy of the Institute that such faculty exchange with other facilities helps maintain awareness of current progress within their fields by faculty members.

Questions concerning health care services at the Institute may be addressed to:

Admitting Physician's Office
William S. Hall Psychiatric Institute
Drawer 119
Columbia, South Carolina 29202

Or call Area Code 803, 256-9911, Extension 514.

Questions concerning training programs and research activities at the Institute may be addressed to the:

Associate Director of Research and Training
William S. Hall Psychiatric Institute
Drawer 119
Columbia, South Carolina 29202

TRAINING

The training program in general psychiatry at the Institute is fully accredited for the complete three-year period, and provisional approval has been granted for a training program in child psychiatry. In addition, there are post graduate programs in psychiatry and neurology offered for physicians whose primary areas of practice are in other fields. In addition to medical students from the Medical College of South Carolina who come to the Institute as part of their training, externships are offered at various levels to medical students of all accredited medical schools. Training programs of other disciplines within the mental health field which are currently approved include internships in clinical psychology and clinical pastoral counseling. There are also affiliated training programs for psychiatric nursing, occupational therapy and psychiatric social work. The varied disciplines of the faculty at the Institute offers a spectrum of approaches health and behavioral problems which is not only clinically useful, but is felt also to be beneficial to trainees of the various disciplines.

INTERNSHIPS—CLINICAL PSYCHOLOGY

(William S. Hall Psychiatric Institute)

The William S. Hall Psychiatric Institute, located in Columbia, South Carolina, is a teaching, training, and research facility of the South Carolina Department of Mental Health. It is an ultramodern facility consisting of five inpatient wards including ones in neurology and adolescence, outpatient adults, child and adolescence sections, a professional library, offices, classrooms, and other related facilities. All of the usual professional areas are represented and staffed by qualified professionals. In addition, the Institute has close contact and interaction with a number of the local agencies and facilities, including the Columbia Area Community Mental Health Center, the Columbia Drug Abuse Center, and the nearby University of South Carolina. Associated with all this is a wide variety of consultants, seminars, and lecture series. The Institute is mainly financially supported by the state, but some areas have NIMH support for programs. The Clinical Psychology Internship Program currently is partly supported by NIMH for training.

Psychology interns receive training under close supervision in the areas of psychological evaluation, group and individual psychotherapy with children, adolescents, and adults, and various other professional experiences. Participation in sensitivity groups for nursing students, lectures, talks and interaction with other professionals in training, and other ongoing programs is part of the training. The intern is encouraged and given time to involve himself in research projects and to develop his own research interests. Time to work on dissertation will usually be available. In general, training is suited to the individual needs and interests of the intern. There are three rotations of four months each, one in the child and adolescent section, one in the inpatient section, and one in the community mental health center. There is available a considerable variety of experiences. Present training staff consists of seven Ph.D. psychologists with more anticipated as needed.

Applicants should be Ph.D. candidates with at least two years of graduate study. The stipend for a year is $7,000. For further information, write to William Rothstein, Ph.D. Chief, Psychology Service, William S. Hall Psychiatric Institute, Drawer 119, Columbia, South Carolina 29202.

Columbia, the capitol of South Carolina, is a rapidly growing city located in the geographical center of the state with a population of over 300,000 in the metropolitan area. Mountains and beaches are two hours drive from the city. The climate is excellent for year-round outdoor recreation. There are four colleges in Columbia, including the University of South Carolina. Cultural facilities are adequate. Cost of living is considered to be not particularly high or low.

CONTINUING EDUCATION FOR CLERGY

Schedule of Part Time Programs, 1971

Presented by Pastoral Education Service, William S. Hall Psychiatric Institute,
of the
South Carolina Department of Mental Health Columbia, South Carolina

Realizing the heavy demands on a parish clergyman's schedule, these 1971 programs as listed below are designed specifically for clergy and other pastoral workers who desire a continuing education experience in pastoral care at the William S. Hall Psychiatric Institute on a part-time rather than a full-time basis.

No. 1 Seminar on Pastoral Group Counseling

One-half day (each Tuesday morning) from April 6 through May 25, 1971; limited to 12 participants; $15.00 registration fee.

An examination of the psychological and theological dimensions of group processes as applied to pastoral care groups. Attention is given both to theoretical and experienced learning via discussion of theory and also the participant's experiencing himself in group interaction.

No. 2 Pastoral Studies Program: 'Ministry to Youth in a Changing Society'

One day a week (each Friday) for three weeks in May, 1971 (May 14, 21, and 28); limited to 20 participants; $8.00 registration fee.

An exploration of relevant pastoral care in response to the emotional needs of youth, with special emphasis on today's cultural context. The course will include lectures, case conferences, selected readings, and discussion groups.

No. 3 Pastoral Studies Program: 'Crisis Counseling in Pastoral Care'

One day a week (each Tuesday) for the month of October, 1971 (October 5, 12, 19, and 26); limited to 20 participants; $10.00 registration fee.

A consideration of pastoral care and the parish crises of death, alcoholism, family conflict, and mental illness. Films, lectures, and discussion groups will be offered.

No. 4 Part-Time Clinical Pastoral Training

A total of 32 days distributed in four blocks of time from October 25 through December 13, 1971: (1) five days weekly for three consecutive weeks (2) one day during the fourth week (3) five days weekly for three more consecutive weeks and (4) one final day during the eighth and final week; if desired by participant, room and board can be offered at total of approximately $30; successful completion of training is acknowledged as one-half Unit of certified Clinical Pastrol Education; limited to 6 participants; $25.00 registration fee.

This course provides an intensive period of pastoral care training with a focus on the transfer of clinical learning about the human predicament to that of parish ministry. Structures of training are ward assignments, interprofessional lectures, seminars, funstioning on a clincal treatment team, supervisory conferences, pastoral counseling with patients, and participation with community resources.

*Certificates of successful completion are awarded at the end of each program
*Faculty is composed of representatives from various mental health professions.
*Lunch is included in registration fee (except course No. 4).
*Interested persons are invited to inquire about the full-time Clinical Pastoral Education programs offered at the William S. Hart Psychiatric Institute.
*Watch next year for the 1972 announcement of part-time programs.

SUMMARY OF PROGRAM

In the early 1960's, the South Carolina Department of Mental Health was confronted with a crisis due to the lack of trained mental health professionals. Efforts to recruit out of state were unsuccessful, and attempts to train required personnel in a service-oriented state hospital were not producing the desired results. Convinced that only a bold new approach would succeed in developing the quality training and the numbers required, the decision was made to establish an autonomous training and research facility within the Department of Mental Health. In May, 1965, the South Carolina Legislature established the William S. Hall Psychiatric Institute and assigned it the mission of training mental health professionals and conducting psychiatric research. Although lacking affiliation with a medical college or university, the Institute in a period of six and one-half years has developed approved training programs in all disciplines in the mental health field and in this short period has attained the capability of training the mental health professionals required to staff a comprehensive mental health program for the State of South Carolina.

During the 1950's, authorities in the mental health field with the willing support and encouragement of the state government initiated a comprehensive program to upgrade the mental health facilities in South Carolina and improve the care and treatment rendered those individuals suffering from emotional and mental disorders. By the late 1950's, it was quite obvious that the shortage of trained mental health professionals was preventing the establishment of efficient and effective treatment programs. Efforts to recruit mental health personnel from out of state were intensified but proved unsuccessful, and training programs capable of producing the required personnel were nonexistent. In order to alleviate this situation, a decision was made in the early 1960's to establish a residency program in general psychiatry in the South Carolina State Hospital. This was soon accomplished with applicants accepted for all three years of training. Due to the great demand for service in the State Hospital and the national trend to move residency training out of the state hospital setting, it soon became evident that the residency program would not meet the rapidly expanding need of the state. Convinced that only a bold new approach would succeed in developing the quality and scope of training needed, a decision was made to withdraw gradually from the state hospital setting to a facility devoted specifically to training and research. Fortunately, a newly constructed hospital-cottage complex was available which met the needs of such a facility. At the request of the South Carolina Department of Mental Health, the State Legislature in May, 1965, passed a bill establishing the William S. Hall Psychiatric Institute as an autonomous institution within the Department of Mental Health. This legislation assigned the Institute the sole mission of training mental health workers and conducting psychiatric research and provided that patients should be admitted upon the approval of the Institute Director based on the needs of the training program.

Efforts during the next eighteen months were devoted to selecting a teaching staff, program planning, and establishing the hospital to support the training programs. In order to provide the clinical setting required to support the training programs at the Institute, the following clinical and supporting services were established: three 23-bed adult psychiatry inpatient units, one 23-bed neurology inpatients unit, one 14-bed adolescent psychiatry inpatient unit, a day treatment center for twelve emotionally disturbed children, an adult psychiatry outpatient service, a child and adolescent psychiatry outpatient service, a neurology child and adult outpatient service, and a consultation service in psychiatry and neurology. Supporting services include nursing, psychology, social work, occupational therapy, recreational therapy, vocational rehabilitation, and administrative services which include an outstanding professional library. The first inpatient was admitted in September, 1966. The Institute was surveyed by the Joint Commission on Accreditation of Hospitals in April, 1968, and received full accreditation for three years.

During the development of the clinical program, planning and development of the training program continued. A basic philosphy developed during this period was that since an interdisciplinary team approach would be used in patient treatment, the same approach would be used in training, that training programs would be developed in all disciplines, and, wherever possible, training would be on a team basis.

In order to carry out its mission of training the personnel required to support the state mental health program, the Institute has established the following programs:

1) A 3-year residency program in general psychaitry. This program was surveyed by the Council on Medical Education of the American Medical Association in November, 1968, and received full approval. Eleven residents are currently enrolled in this program which has a goal of six residents in each year of training.
2) A 2-year fellowship in child psychiatry. This is the first and only program training child psychiatrists in South Carolina. It was surveyed by the Council on Medical Education and received full approval in May, 1971. Six fellows are now training in this program. Plans are to train four fellows in each year of training.
3) A clincial psychology internship program offering the one year of clinical internship required for the Ph.D. This is the first clinical internship program organized in the state and is in the process of being surveyed for approval by the American Psychological Association. There are five interns currently enrolled in this program which was initially established to train four interns annually.
4) A social work field placement program which provides a practicum placement for first and second year graduate students pursuing a masters degree in social work. This is a 9-month placement with four students enrolled in each year of training.
5) A clinical pastoral education program consisting of a 12-month course offered each year for ordained ministers and a 3-month course offered each summer for four seminary students. This program was surveyed and approved by the Association of Clinical Pastoral Education, Inc., in August, 1967. Current enrollment in this program consists of four ordained ministers and four seminary students.
6) An occupational therapy internship program providing four 3-month internships each year for three students each quarter. This internship in a psychaitric setting is a requirement for the bachelors degree in most schools of occupational therapy. A training program, six months in length, has also been initiated to train certified occupational therapy assistants. This program was designed to alleviate the shortage of registered occupational therapists in this state. This shortage of occupational therapists is due primarily to the absence of a university program in occupational therapy in this state.
7) A recreational therapy internship program consisting of a 3-month internship for students seeking a bachelor's degree in recreational therapy and a 9-month internship for candidates for a masters degree in recreational therapy. Six students seeking the bachelors degree and two seeking the master's degree can be trained in this program annually.

8) A nursing education program provides three months of training in a psychiatric setting for student nurses. This training is a requirement for licensure as a registered nurse in South Carolina. Four courses are conducted annually for thirty nursing students per course.
9) A continuing education program providing short courses in the field of mental illness for nonpsychiatric physicians throughout the state.
10) A special education teachers' program provides placements for teachers seeking a bachelors or masters degree in special education for emotionally disturbed children. This program is provided on a year-round basis with the length of the course determined by the needs of the student.
11) A medical externship program which provides three months' experience in the psychiatric field for medical students during the junior and senior years of medical school.
12) A vocational rehabilitation internship program, three months in length, provides training in the psychiatric setting for the masters degree in vocational rehabilitation.

In addition to the existing programs, new training programs will be initiated in the near future. A neuropsychiatry fellowship program, one year in length, will provide for the integrated teaching of neurology and psychiatry to two fellows annually. An adolescent psychiatry fellowship program will be initiated to meet the growing need for specialists in this field. Two fellows will be trained in this program annually.

During the first five years, major emphasis was placed on the development of clinical services and training programs at the expense of our research program. This situation was necessary because our developing staff was unable to pursue both programs concurrently. In early 1970, it was decided that the training programs had developed to the point where major emphasis could be shifted to expanding and upgrading of the research program. A modern research laboratory has been constructed and equipped to perform research in the areas of chemistry of the brain, histochemical analysis, and the use of radioisotope techniques to investigate the absorption, distribution, metabolism, and excretion of the drugs used in the field of psychiatry. In the neurologic and psychiatric fields, members of the staff have engaged increasingly in research with numerous studies and investigation under way; and many scientific papers have been published. The Institute publishes semiannually *The Psychiatric Forum*, a scientific journal which presents the thoughts and studies of experts in the field of mental health. A primary purpose of this journal is to encourage and provide the means for the publication of student papers.

As the end of the seventh year since passage of the legislation establishing the Institute approaches, there is plentiful evidence that the Institute is fulfilling its mission. Skepticism concerning our ability to create an academically-oriented teaching facility not a part of a medical college or university has disappeared. This situation has not adversely affected our clinical or teaching programs, nor has it been detrimental to the securing of a highly qualified teaching staff. A full-time teaching faculty of twelve psychiatrists, one neurologist, one child neurologist, five Ph.D. clinical psychologists, one Ph.D. phamacologist, ten MSW social workers, two masters degree recreational therapists, one masters degree vocational rehabilitation counselor, three occupational therapists, and a part-time faculty of twenty-five psychiatrists, neurologists, and allied scientists maintain the highest academic standards incorporating the lastest teaching devices and techniques. In retrospect, it appears that the supposition that the only hope of meeting the requirements for mental health professionals in South Carolina rested upon a successful training program in the state, and the decision to establish a separate teaching and research facility to conduct the program was correct. After only six and one-half years, the William S. Hall Psychiatric Institute is capable of producing the trained personnel required to provide a quality mental health program for the citizenry of South Carolina; and, in the opinion of the staff of the William S. Hall Psychiatric Institute, this accomplishment is worthy of note.

EPISCOPAL CHURCH HOME FOR CHILDREN, YORK, SOUTH CAROLINA

"DESCRIPTION OF SERVICES"; AND ADDRESS TO DIOCESE OF UPPER SOUTH CAROLINA BY H. S. HOWIE, JR., EXECUTIVE DIRECTOR, EPISCOPAL CHURCH HOME FOR CHILDREN

H. Sanford Howie, Jr., ACSW	Executive Director
P. Eugene Knight	Assistant to the Executive Director Director of Cottage Life
Wendell A. Horton, ACSW	Director of Social Service
Mrs. Rachel Hope	Caseworker
Mr. Robert Hawkins	Caseworker
Charles A. Abercrombie, MSSW	Director, Gadsden Treatment Center
Robert C. Schnackenburg, M.D	Psychiatric Consultant
George R. Holmes, Ph.D	Psychological Consultant
Wendell A. Horton, ACSW	Director, Greene Adolescent Girls Center
John Hughes, M.D	Psychiatric Consultant
George R. Holmes, Ph.D	Psychlogical Consultant

The philosophy of care set forth in this description is embodied in our best professional knowledge and understanding as we feel it to date. We try to hold on to those things which continue to be valid but no belief is too sacred to be altered in the lisht of new knowledge.

The science of human behavior is a relatively new one and has very few absolutes. Indeed, many of these are being overturned and questioned regularly.

Our services which involve placement away from home are predicated on the belief that a child is always better served in his own home, when he can get the help he needs; and that this is increasingly true, the younger the child. Financial need alone is seldom sufficient reason to separate a child from his family. Natural parents, no matter how inadequate can often be helped to better fulfill their responsibilities.

All programs are geared to short term stay—usually six months to several years. At the same time plans are being made for admission of a child, plans are also being made for his eventual return home.

The Church Home is not equipped to serve children who are retarded in any of its programs, even though the emotionally disturbed children in our treatment center sometimes function on this level. If the special education classes in each community are not sufficient to meet the child's needs, there are state institutions for the retarded if placement is being considered.

A Request for Services Form is available by writing Executive Director, Church Home for Children, York, South Carolina 29745. All applications are studied and decisions made subject to available space and this usually results in a waiting period.

The Church Home offers five areas of service for children in South Carolina:

I. Group Care
II. Foster Home Care
III. Family Counseling
IV. Emergency Care Funds
V. Residential Treatment for Emotionally Disturbed Children

I. *Group Care* on our York campus serves boys and girls of at least school age in cottages with a maximum capacity of twelve. There is no upper age limit except for that inherent in attending the public schools.

These three cottages are part of the Main Campus but they also exist as separate units. With a housemother they plan their own schedules, menus, and general living arrangements. Casework services are a part of placement, and regular visitation at home is expected.

Cost for this program is approximately $300 per month and arranged on an ability to pay scale.

II. *Foster Home Care*—We have a very limited number of foster homes but try to arrange such placement for children who can profitably use a natural family setting. The child and his foster family maintain regular contact with the Church Home Casework Staff and his natural family.

III. *Family Counseling*—Professional counselors are available at the request of clergyman to help hold together the very heart of Christian tradition—the family.

IV. *Emergency Care Funds*—Clergymen may turn to Church Home for funds to assist families on a temporary emergency basis.

TAYLOR RESIDENTIAL TREATMENT CENTER (ALSO ACCEPTS GIRLS)

V. *Gadsden Residential Treatment Center*

General Criteria

Boys in the age range of 7–13
Primary problem not organic or retardation
Family willing to be involved
  (Parents group meets twice each month)
  (Home visit for holidays and at least one weekend each month)
Group composition influences admission decision
8 residential and 2 day care spaces

Procedure

Psychiatric and psychological evaluation as near home community as possible
Request for Services Form secured from Executive Director
Arrangements for campus visit and additional evaluation
Decision by Admissions and Planning Council (All decisions pending space. There is usually a waiting list)

Staff

Resident Director—MSW
Consultant Psychiatrist
Consultant Psychologist
House Counselors
Teacher
Auxiliary Personnel, including college student assistants, dietician, custodial worker

Cost

$600 per month, on an ability to pay schedule.
Not a criteria for admission.

COST BREAKDOWN FOR RESIDENTIAL TREATMENT SERVICES

These cost estimates were reached with the help of the current Duke Endowment figures (to be published in March) as a frame of reference.

Where applicable, they were used exactly. Where there was an obvious variation for an exclusive treatment program they were used as a starting point. For example, food costs would be the same but household slaries would not.

	Day	Month	Year
Psychological and medical services	6.74	205.00	2,460.10
Room rate (ward 4 and semiprivate)	14.34	436.17	5,234.10
Total	21.08	641.18	7,694.20
General administrative costs	3.62	110.10	1,321.30
Grand total	24.70	751.29	9,015.50

Note: Some apparent addition errors due to extended decimal point.

A SHORT ADDRESS TO THE CONVENTION, DIOCESE OF UPPER SOUTH CAROLINA, TRINITY CHURCH, COLUMBIA, S.C., FEBRUARY 5, 1972, BY H. S. HOWIE, JR., EXECUTIVE DIRECTOR, EPISCOPAL CHURCH HOME FOR CHILDREN

I think that only in future years and in retrospect will the Church be able to fully appreciate the leadership of the Board of Trustees of the Church Home for Children—a Board which, in the early 60's foresaw some of the changes coming in child care and with the help of our national Church sent its executive back to school for professional training—the Board which today not only has the Church in the middle of the most critical need of children in our state—but actually in the forefront, leading the way.

You will be interested to know that last month Mr. H. B. Richardson of this Diocese was elected President of our Board of Trustees after two years as Chairman of our Finance Committee.

The ten boys who were returned to their own homes in the first two years operation of the Gadsden Treatment Center of the Church Home represent a total investment of $168,000. on your part. Today there are twelve who have been released but these figures are compiled from the first ten. With the addition of Taylor Treatment Center this year we are now able to serve a total of sixteen children at one time.

Remember that we are here dealing with the most devasting of all man's health problems. . . . mental illness . . . the health problem that has implications for all of us, not just the families and friends of the victims.

In our follow up work with these boys, nine white and one black, we know that all are now doing well in their own homes . . . some dramatically so . . . better able to bear up under the stresses they found so unbearable before. Keep in mind that, though none are retarded and indeed several possess a superior intelligence, all had been excluded from a succession of public and private schools. . . . They came to us from counties like Sumter, Greenville, Spartanburg, Horry, Richland, Beaufort, York, Anderson and Charleston . . . Their medical diagnoses run the gamut from Acute Personality Disorder to Childhood Schizophrenia.

When Henry Barton asked me earlier this week about a young man recently admitted and with whom he was familiar my reply was that he was "giving us fits" at this time . . . but this was the reason he was with us. He couldn't get along elsewhere and we have the strength built in to deal with difficult times . . . one of the reasons for the high cost of this service.

It would be presumptuous to say that none would ever need professional help again . . . and indeed some have not gone home . . . Many have been on shaky ground for most of their lives and even pure medical hospitals don't provide 100% cures all of the time.

But they were reached at a most important time in their lives . . . a time when mental illness is most reversible . . . and they responded well.

I think it *is not* presumptuous to predict that, *without* this help from the Church, most would have spent their adult lives in our state institutions . . . take your pick.

The following statistics represent some assumptions on my part, but I think not unrealistic assumptions and, if anything greatly weighted on the conservative side.

Senator Waddell has, in this morning's State, estimated the cost to the state in one of our institutions for the life expectancy of a child as one million dollars for every six.

For the sake of the very conservative estimate I mentioned and the convenience of Senator Waddell's figures, suppose only six of these ten boys would have faced life time institutionalization in South Carolina.

To this amount we must add the other side of the picture . . . the 40 year work expectancy as a productive human being . . . . a total tax estimate for the six of them to the state of South Carolina of $36,000. (not even considering federal taxes at this time).

One million dollars, plus $36,000 equals the amount from which we subtract our investment of $168,000 and our balance sheet shows a savings (or a profit if you will) to our state of $868,000 . . . This in itself has other implications for finances, but not today.

These items represent the purely "business outlook" and, thanks be to God, the Church has also another outlook . . . the one you have heard from me in the past . . . the compassion that says, ("Even more important than all of this is the salvaging on just one human personality." This truly is responding to God's unending love for us by loving one of the least of these.

The real test of this love comes about when it is loving those who are not always so easy to love . . . We have no trouble loving our friends and loving those "lovable" children we have served for so many years (and who, at one time, very much needed our care) . . . Ladies and gentlemen, I assure you that these children of God we are serving today are not always so easy to love . . . but even so, they never cease to be God's children.

Every time we go through a particularly difficult period with one of these children . . . maybe for a few hours, maybe for a few days, and maybe even for months . . . a human being so damaged . . . so overwhelmed . . . and so ferociously determined that no one is ever going to get close enough to him to again hurt him . . . every time we go through this I feel I know a little bit more what Jesus was talking about when he spoke of the "least of one of these" . . . and it doesn't have much to do with physical stature.

In 22 years of work with children and young people I have never been involved in anything I consider more significant—and meeting a more desperate need. In the realm of our own Christian mission these ten boys represent ten of the most important persons in my life—and yours!

I listened to Ernest Boatwright yesterday after that excellent report on Camp Gravatt—and Ernest serves very ably also on our Finance Committee—and he said that he hoped he could submit his report by title next year . . . I wish I could even envision such a thing but I know I will probably be right back speaking about the same things and trying to get all of you as caught up in this as many of us are—for it seems that no matter how much we accomplish there still remain "many more miles to go and many more promises to keep."

Thanks.

LIVE-IN FACILITIES FOR EMOTIONALLY DISTURBED CHILDREN—PREPARED BY D.C. MENTAL HEALTH ASSOCIATION

I. Type of institution or setting	II. Description of child	III. Average stay	IV. Facilities available		V. Cost	VI. Priority need
A. Residential treatment center or program—A small, semi-institutional setting, preferably not more than 20 beds, for children only. Staff may be medical or nonmedical but have available both psychiatric and medical consultation and supervision. Staff typically includes psychiatrists, psychologists, social workers, teachers, occupational and recreational therapists. Program offers a variety of treatment methods, individual and group therapy, special teaching methods, recreation. A day program is usually included for children who can live at home and spend the day at the center, with a flexible in-and-out program to suit needs of individual child. Parents and others in the child's environment (teachers, etc.) are involved in the treatment plan. The goal is to keep the child in touch with his natural setting and to return him to his home as soon as possible. One 20-bed unit might accommodate as many as 100 children because of combined living in and day care programs.	A. Child may show some of the symptoms listed above and may have the same diagnosis but his problems are generally less severe than those of children requiring hospitalization. Symptoms and behavior may include trouble in getting along with other children (excessively shut in or too agressive, etc.), difficulties at home (e.g. running away, excessive fighting, rages, crying, stealing, bed-wetting, eating and sleeping problems), learning and/or discipline problems at school—e.g. inability to get along with other children, slow learning despite good intelligence, being a "misfit," day-dreaming in class, persistent truancy, etc. Some behavior may border on delinquency. For placement in residential treatment, child must be able to fit in to some extent in a small group program, and must show some evidence of being able to benefit from it. Goal is early return to home, whether own or foster home.	A. Few weeks to 6 months or year.	A. Public—None..........	Private[1]—Approximately 300 beds in 7 local institutions, Christ Child Institute, Edgemead Episcopal Center, Linwood School, Hillcrest Center, Psychiatric Institute, Treatment Center for Autistic Children.	A. Estimates run from $11,000 to $20,000 per year per child. (More accurate and inclusive figures can be obtained if needed.	A. 1.
B. Foster homes for disturbed children—Individual or group homes—Family homes with foster parents carefully selected because of special abilities to care for children who show difficult, sick behavior. Such homes are carefully supervised by the sponsoring agency. Parents are given much help from social workers and other specialists in understanding and handling their charges. This requires very frequent home visits, having staff available at all times for emergencies	B. Children may show some or all of the symptoms and behavior described above. Choice of foster home rather than residential center depends on such considerations as: Child's inability to fit into group living; Lack of own parents to whom child can return; child's need for special individual affection and care.	B. From few months up to minority (18 or 21) depending on own home situation.	B. Public—None meeting standards described in I. C. Child Welfare Division of District of Columbiaa Social Services Administration have about 50 foster homes who care for emotionally disturbed children undergoing clinical treatment. These homes receive small	Private[1].—Family and Child Service has 30 foster families for disturbed children, Jewish Family Agency, 3, "FLOC," and Catholic Charities have some disturbed children in their individual and group foster homes, but no homes set up specifically for care of	Private—Family and Child Service, $455 per month. Public—Standard foster care—$100 and $40 per month "service charge" per child and cost of transportation to clinics.	B. 2.

(such as runaways, sudden outbreaks of violent behavior, etc.). Such homes are financially subsidized beyond the cost of usual foster care. Individual homes may have 1 to 3 children. Group homes may care for more, but the number has to be kept small because of special needs of these children.			additional subsidies for transportation, babysitting, etc.	emotionally disturbed children. Family and Child Services have some group foster homes not specifically used for disturbed children.		
C. Psychiatric Hospital—An institution staffed by medical and psychiatrically trained personnel and equipped with facilities for physical and psychiatric treatment. This includes use of medications, and laboratories for diagnosis of wide variety of neurological and psychiatric disturbances. Ideally should treat children only, but is generally an adult hospital with special wards or units for children. Treatment methods vary depending on the institution. Many provide little but custodial care.	C. Severe mental or emotional illness (psychosis, brain damage, severe neurological disturbance, etc.). Symptoms may include marked withdrawal from reality (e.g. not eating, not talking, coma-like appearance), extreme aggression toward others, suicidal thoughts or attempts, as well as less severe disturbances. Many of these children cannot care for bodily needs, or have eating difficulties, which require special attention from staff. Some have been disturbed since birth. Most are unable to learn in a regular school, but some can benefit from special education methods within the hospital.	C. Few weeks to several years.	C. Public (estimate 1971)—1. St. Elizabeths Hospital Youth Center, about 15 beds, Area D Mental Health Unit (about 20 beds), few scattered beds on adult wards; 2. District of Columbia General Hospital—about 12 beds available to area C DCMHA for short-term emergency care only; 3. Freedmen's Hospital (few beds, mostly for adolescents).	Private—(estimated 1971) 75 beds mostly for adolescents in 3 hospitals: George Washington Hospital; Washington Hospital Center; Hospital for Sick Children.	C. St. Elizabeths Hospital, $31.10 per day per patient (District of Columbia government pays $18.90 per day to hospital for care of District of Columbia patients). (Cost of private hospital care not obtained.)	C. 3.

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[1] The District of Columbia government places some emotionally disturbed children by contract and tuition grants in private facilities in District of Columbia and other areas of the United States. Current figures. Board of Education tuition grants, 79 (in 1970–71—Board of Education reported 800 children diagnosed as emotionally disturbed or socially maladjusted). Department of Human Resources, Children's Services, 7; Mental Health Administration (contract), 5.

CIVIL ACTION SUIT IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

PETER MILLS AND OTHERS v. BOARD OF EDUCATION OF THE DISTRICT OF COLUMBIA AND OTHERS

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA
(CIVIL ACTION NO.)

PETER MILLS, resident at Junior Village, a minor by his next friends, D.C. FAMILY WELFARE RIGHTS ORGANIZATION, 1200 Delaware Avenue, S.W., Washington, D.C., RONALD V. DELLUMS, 1749 North Portal Drive, N.W., Washington, D.C., and REV. FRED TAYLOR, 7305 Gordons Road, Falls Church, Virginia; DUANE BLACKSHEARE, resident at Saint Elizabeth's Hospital, Washington, D.C., a minor by his next friend, EASTER BLACKSHEARE, 130 V Street, N.W., Washington, D.C.; GEORGE LIDDELL, JR., 601 Morton Street, N.W., Washington, D.C., a minor by his next friend, DAISY LIDDELL, 601 Morton Street, N.W., Washington, D.C.; STEVEN GASTON, 714 9th Street, N.E., Washington, D.C., a minor by his next friend, INA GASTON, 714 9th Street, N.E., Washington, D.C.; MICHAEL WILLIAMS, resident at Saint Elizabeth's Hospital, Washington, D.C., a minor by his next friend, MARVA WILLIAMS, 641 Condon Terrace, S.E., Washington, D.C.; JANICE KING, 233 Anacostia Avenue, N.E., Washington, D.C., a minor by her next friend, ANDREW KING, 233 Anacostia Avenue, Washington, D.C.; JEROME JAMES, 2512 Ontario Road, N.W., Washington, D.C., a minor by his next friend, MARY JAMES, 2512 Ontario Road, N.W., Washington, D.C., PLAINTIFFS

v.

BOARD OF EDUCATION OF THE DISTRICT OF COLUMBIA; HUGH J. SCOTT, individually and as Superintendent of Schools for the District of Columbia; ANITA ALLEN, individually and as President of the Board of Education of the District of Columbia; REV. JAMES E. COATES, MURIEL M. ALEXANDER, CHARLES I. CASSELL, EDWARD L. HANCOCK, NELSON C. ROOTS, ALBERT A. ROSENFIELD, MARTHA S. SWAIM, MATTIE G. TAYLOR, BARDYL R. TIRANA, and EVIE M. WASHINGTON, individually and as members of the Board of Education of the District of Columbia; JOHN L. JOHNSON, individually and as Associate Superintendent of Schools for the District of Columbia in charge of the Department of Special Education; STANLEY E. JACKSON, individually and as Executive Assistant to the Associate Superintendent of Schools for the District of Columbia; MAMIE H. LINDO, individually and as Supervising Director of the Department of Special Education for the District of Columbia Public Schools; DOROTHY JOHNSON, individually and as Assistant Superintendent of Schools for the District of Columbia in charge of the Department of Elementary Education; VINCENT REED, individually and as Assistant Superintendent of Schools for the District of Columbia in charge of the Department of Secondary Education; WILBUR A. MILLARD, individually and as Assistant Superintendent of Schools for the District of Columbia in charge of the Department of Pupil Personnel Services; WALTER E. WASHINGTON, individually and as Commissioner of the District of Columbia; PHILIP J. RUTLEDGE, individually and as Director of the Department of Human Resources of the District of Columbia; WINIFRED THOMPSON, individually and as Director of the Social Services Administration of the District of Columbia Department of Human Resources; EULA DELAINE, individually and as Administrator of Junior Village; VESTA RANDALL, individually and as School Liaison Officer of Junior Village; and DISTRICT OF COLUMBIA, DEFENDANTS

PRELIMINARY STATEMENT

1. Plaintiffs are school age children who have been excluded entirely from the District of Columbia Public Schools and at the present time are being denied a publicly-supported education by the District of Columbia. Plaintiffs are predominately black and poor and without financial means to obtain private instruction.

2. Plaintiffs have been denied admission to the District of Columbia Public Schools or have been excluded subsequent to admission. Plaintiffs were so excluded without a formal determination of the basis for their exclusion and without provision for periodic review of their status. Plaintiff children merely have been labeled as behavioral problems, mentally retarded, emotionally disturbed or hyperactive. Plaintiffs can profit from an education, whether in regular classrooms with supportive services or in special classes adapted to their needs, and seek to obtain such instruction.
3. Plaintiffs, as a result of Defendants' conduct, have not received an education for substantial periods of time. They have been denied access to the District of Columbia Public Schools and have not been provided with specialized instruction adapted to their needs in public or private schools.
4. Defendants deny plaintiffs a publicly-supported education while providing such an education for other school age children in the District of Columbia.
5. Defendants' acts and practices in denying plaintiffs an equal educational opportunity violate the Fifth Amendment of the Constitution of the United States, the applicable statutes of the District of Columbia, and the applicable Rules of the Board of Education of the District of Columbia. Plaintiffs seek declaratory, preliminary and permanent injunctive relief to prevent continued educational deprivation in violation of their rights.

JURISDICTION

6. The jurisdiction of this Court is invoked under 28 U.S.C. §§ 1331, 1343, 2201; 42 U.S.C. § 1983, this being an action for declaratory, preliminary and permanent injunctive relief to redress the deprivation under color of law of rights, privileges, and immunities secured to plaintiffs by the Constitution and laws of the United States. The amount in controversy exceeds Ten Thousand (10,000) Dollars.

PLAINTIFFS

7. PETER MILLS is twelve years old, black, and a committed dependent ward of the District of Columbia resident at Junior Village. He was exlcuded from the Brent Elementary School on March 23, 1971, at which time he was in the fourth grade. Peter allegedly was a "behavior problem" and was recommended and approved for exclusion by the principal. Defendants have not provided him with a full hearing or with a timely and adequate review of his status. Furthermore, Defendants have failed to provide for his reenrollment in the District of Columbia Public Schools or enrollment in private school. On information and belief, numerous other dependent children of school attendance age at Junior Village are denied a publicly-supported education. Peter remains excluded from any publicly-supported education. [See attached Affidavits, Appendix A]
8. DUANE BLACKSHEARE is thirteen years old, black resident at Saint Elizabeth's Hospital, Washington, D.C., and a dependent committed child. He was excluded from the Giddings Elementary School in October 1967, at which time he was in the third grade. Duane allegedly was a "behavior problem." Defendants have not provided him with a full hearing or with a timely and adequate review of his status. Despite repeated efforts by his mother, Duane remained largely excluded from all publically-supported education until February, 1971. Education experts at the Child Study Center examined Duane and found him to be capable of returning to regular class if supportive services were provided. Following several articles in the *Washington Post* and *Washington Star*, Duane was placed in a regular seventh grade classroom on a two-hour a day basis without any catch-up assistance and without an evaluation or diagnostic interview of any kind. Duane has remained on a waiting list for a tuition grant and is now excluded from all publicly-supported education. [See attached Affidavit, Appendix B].
9. GEORGE LIDDELL, JR., is eight years old, black, resident with his mother, Daisey Liddell, at 601 Morton Street, N.W., Washington, D.C., and an AFDC recipient. George has never attended public school because of the denial of his application to the Maury Elementary School on the ground that he required a special class. George allegedly was retarded. Defendants have not provided him with a full hearing or with a timely and adequate review of his status. George remains excluded from all publicly-supported education, despite a medical opinion that he is capable of profiting from schooling, and despite his mother's efforts to secure a tuition grant from Defendants. [See Affidavit, Appendix C]
10. STEVEN GASTON is eight years old, black, resident with his mother, Ina Gaston, at 714 9th Street, N.E., Washington, D.C., and unable to afford private instruction. He has been excluded from the Taylor Elementary School since

September, 1969, at which time he was in the first grade. Steven allegedly was slightly brain-damaged and hyperactive, and was excluded because he wandered around the classroom. Defendants have not provided him with a full hearing or with a timely and adequate review of his status. Steven was accepted in the Contemporary School, a private school, provided that tuition was paid in full in advance. Despite the efforts of his parents, Steven has remained on a waiting list for the requisite tuition grant from Defendant school system and excluded from all publicly-supported education. [See attached Affidavit, Appendix D]

11. MICHAEL WILLIAMS is sixteen years old, black, resident at Saint Elizabeth's Hospital, Washington, D.C., and unable to afford private instruction. Michael is epileptic and allegedly slightly retarded. He has been excluded from the Sharpe Health School since October, 1969, at which time he was temporarily hospitalized. Thereafter Michael was excluded from school because of health problems and school absences. Defendants have not provided him with a full hearing or with a timely and adequate review of his status. Despite his mother's efforts, and his attending physician's medical opinion that he could attend school, Michael has remained on a waiting list for a tuition grant and excluded from all publicly-supported education. [See attached Affidavit, Appendix E]

12. JANICE KING is thirteen years old, black, resident with her father, Andrew King, at 233 Anacostia Avenue, N.E., Washington, D.C., and unable to afford private instruction. She has been denied access to public schools since reaching compulsory school attendance age, as a result of the rejection of her application, based on the lack of an appropriate educational program. Janice is brain-damaged and retarded, with right hemiplegia, resulting from a childhood illness. Defendants have not provided her with a full hearing or with a timely and adequate review of her status. Despite repeated efforts by her parents, Janice has been excluded from all publicly-supported education. [See attached Affidavit, Appendix F].

13. JEROME JAMES is twelve years old, black, resident with his mother, Mary James, at 2512 Ontario Avenue, N.W., Washington, D.C., and an AFDC recipient. Jerome is a retarded child and has been totally excluded from public school. Defendants have not given him a full hearing or a timely and adequate review of his status. Despite his mother's efforts to secure either public school placement or a tuition grant, Jerome has remained on a waiting list for a tuition grant and excluded from all publicly supported education. [See attached Affidavit, Appendix G].

14. The D.C. Family Welfare Rights Organization is a membership organization which acts to protect the interests of the poor, including committed dependent children. The D.C. Family Welfare Rights Organization represents three thousand families, many of whose children have been excluded from all publicly-supported education.

15. EASTER BLACKSHEARE, DAISY LIDDELL, INA GASTON, MARVA WILLIAMS, ANDREW KING, and MARY JAMES sue on behalf of their above-named children as next friend. The D.C. FAMILY WELFARE RIGHTS ORGANIZATION, RONALD V. DELLUMS, and REV. FRED TAYLOR sue as next friends to Peter Mills, a dependent committed ward of the District of Columbia.

THE CLASS

16. Plaintiffs sue on their own behalf and, pursuant to Rule 23, F.R. Civ.P., on behalf of all other District of Columbia residents of school age who are eligible for a free public education and who have been excluded from such an education by Defendants or otherwise deprived by Defendants of access to publicly-supported education. The class is predominantly black and poor, and is so numerous that joinder of all members is impracticable. The questions of law and fact are common to the class. Plaintiffs will fairly and adequately protect the interests of the class and apprise the Court of claims typical to the class. In addition, prosecution of separate actions by individual members of the class would create a risk of inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the local officials opposing the class and a risk of adjudications, with respect to individual members of the class, which would as a practical matter be dispositive of the interests of other members not parties to the adjudications and would substantially impair and impede their ability to protect their interests.

17. Defendants have acted and have failed to act on grounds generally applicable to the class, thereby making preliminary and final injunctive relief appropriate to the class as a whole; to wit, Defendants have wrongfully withheld the right to an equal educational opportunty.

Defendants

18. The BOARD OF EDUCATION OF THE DISTRICT OF COLUMBIA exists pursuant to the laws of the United States governing the District of Columbia and is vested with the legal responsibility for the general control of the public schools. As such, the Board has the authority to determine all questions of general policy relating to the schools and to direct expenditures. Defendant ANITA ALLEN is President of said Board of Education. Defendants REV. JAMES E. COATES, MURIEL M. ALEXANDER, CHARLES I. CASSELL, EDWARD L. HANCOCK, NELSON C. ROOTS, ALBERT A. ROSENFIELD, MARTHA S. SWAIM, MATTIE G. TAYLOR, BARDYL R. TIRANA, and EVIE M. WASHINGTON are all duly elected members of the Board of Education of the District of Columbia.

19. HUGH J. SCOTT is the Superintendent of the District of Columbia Public Schools. As such, he is charged with administrative responsibility for the operation of the District of Columbia school system and for the direction of all matters pertaining to the instruction in the public schools, pursuant to D.C. Code §31–105.

20. JOHN L. JOHNSON is the Associate Superintendent in charge of Special Education for the District of Columbia Public Schools. As such, he is responsible for the design, initiation and implementation of all special programs, services and classes in the District of Columbia Public Schools for physically, mentally or emotionally handicapped District children.

21. STANLEY E. JACKSON is Executive Assistant to the Associate Superintendent in charge of Special Education for the District of Columbia Public Schools. As such, he is responsible for the administration of special education programs in the District of Columbia Public Schools.

22. MAMIE H. LINDO is the Supervising Director of the Division of Special Education for the District of Columbia Public Schools. As such, she is responsible for the administration of the tuition grant program and for the selection and placement of children in the tuition grant program.

23. DOROTHY JOHNSON is the Assistant Superintendent in charge of the Department of Elementary Education of the District of Columbia Public Schools. As such, she is charged with the administrative responsibility for the operation of the District of Columbia elementary schools and for the direction and control of pupil admissions to and dismissals from the elementary schools.

24. VINCENT REED is the Assistant Superintendent in charge of the Department of Secondary Education of the District of Columbia Public Schools. As such, he is charged with the administrative responsibility for the operation of the junior and senior high schools and for the direction and control of pupil admissions to and dismissals from the junior and senior high schools.

25. WILBUR A. MILLARD is the Assistant Superintendent in charge of the Department of Pupil Personnel Services of the District of Columbia Public Schools. As such, he is charged with the administration of testing programs, pupil appraisals, and school attendance investigation.

26. WALTER E. WASHINGTON is the Commissioner of the District of Columbia. As such, he has overall executive responsibility for the operation of the District of Columbia Government, including particularly those functions with respect to requests for appropriations delegated to him by Reorganization Plan No. 3 of 1967, 32 F.R. 11669.

27. PHILIP J. RUTLEDGE is Director of the Department of Human Resources of the District of Columbia. As such, he has responsibility for the care and supervision of all children committed to the care of the Social Services Administration of the District of Columbia Department of Human Resources.

28. WINIFRED THOMPSON is the Director of the Social Services Administration of the District of Columbia Department of Human Resources. As such, she is charged with the responsibility for the care, custody, and guardianship of dependent and neglected children who cannot be properly cared for in their own homes and for the operation of the Social Services Administration in accordance with applicable laws and regulations.

29. EULA DELAINE is the Administrator of Junior Village, an institution wholly maintained and operated by the Social Services Administration and supported by appropriations of Congress for the purpose of the care and treatment of dependent and neglected children. As such, she is charged with the responsibility for the management and direction of Junior Village and for the immediate custody and control of the children residing therein.

30. VESTA RANDALL is the School Liaison Officer for Junior Village. As such, she is charged with the responsibility for the school placement and attendance of Junior Village children in the Public Schools of the District of Columbia.

31. THE DISTRICT OF COLUMBIA is a municipal corporation and may exercise, pursuant to 1 D.C. Code 102, such powers of a municipal corporaton. Through its agencies and instrumentalities, the District of Columbia has the legal responsibility for the custody and supervision of neglected and dependent children, and for providing for the publicly-supported education of school age children of the District of Columbia.

SUMMARY OF FACTUAL ALLEGATIONS APPLICABLE TO THE CLASS

32. At all times material to this cause, plaintiffs have been ready, willing, and able to profit from an education but have been deprived of all opportunity for a publicly-supported education for a substantial period of time.

33. Plaintiffs cannot afford a private education. Therefore, Defendants' denial of access to a publicly-supported education deprives plaintiffs of any and all educational opportunity.

34. Upon information and belief, plaintiffs are denied an equal educational opportunity in that other children similarly situated to plaintiffs in all material respects are given a publicly-supported education in a regular public school classroom or otherwise. In particular, Defendants provide tuition grants, special education programs, or specially trained teachers for a substantial number of other children who have been designated as in need of the same kind of special education services as these plaintiffs.

35. The procedures by which plaintiffs are excluded or suspended from public school are arbitrary and do not conform to the due process requirements of the Fifth Amendment. Plaintiffs are excluded and suspended without: (a) notification as to a hearing, the nature of offense or status, any alternative or interim publicly-supported educational services, or the bases for exclusion or other denial of publicly-supported education; (b) opportunity for representation, a hearing by an impartial arbiter, the presentation of witnesses and evidence; and the confrontation of adverse witnesses; and (c) opportunity for periodic review of the necessity for continued exclusion or suspension.

36. On July 21, 1971, in hearings before the Honorable Judge J. Skelly Wright on a motion to intervene in *Hobson* v. *Hansen*, 26 F. Supp. 401 (1967), in behalf of excluded children, the Corporation Counsel conceded in oral argument that the Board of Education has a legal and moral duty to educate these children.

37. On July 28, 1971, attorneys for the plaintiffs forwarded letters to Defendant Scott and Defendant members of the Board of Education requesting them to take immediate action to admit these and all other excluded children for the 1971 Fall term and to seek whatever emergency appropriations necessary for this purpose.

38. On August 5, 1971, attorneys for the plaintiffs conferred with Defendants Scott and John L. Johnson and their attorney for the purpose of securing the actual admission of those excluded children denied a publicly-supported education. At this meeting, Defendants offered their assurances that the then named petitioners would each be placed in a suitable educational program in the Fall term, and that a full list of the remaining children excluded from a publicly-supported education would be compiled. Plaintiffs were subsequently given assurances through Defendants' attorney that eight out of the ten named petitioners would be placed in programs of publicly-supported education, including plaintiffs Liddell, Williams, King and James.

39. On August 10, 1971, the Defendant Superintendent Scott, in a written memorandum to the Defendant Board of Education, stated that the school system was making "a commitment to expand its limited special education services and to immediately resolve the special problems of these ten students" named in the original suit.

40. In late August, the parents of plaintiffs Blacksheare, Williams, Gaston and James received letters from Defendant Board of Education informing them that the children had been recommended for a special education tuition grant, but remained on the waiting list for such tuition grants.

41. On September 10, 1971, the school attendance year for the District of Columbia Public Schools began. Plaintiff children have received no notification of any school placement for the 1971 Fall term and remain entirely excluded from all publicly-supported education.

FIRST CLAIM FOR RELIEF: DENIAL OF ACCESS TO PUBLICLY-SUPPORTED EDUCATION

42. By denying plaintiffs access to a publicly-supported education, while providing such an education to other District of Columbia children, Defendants violate plaintiff children's rights guaranteed to them by the United States Constitution,

Amendment V, D.C. Code §§31-203 and 31-1101, and District of Columbia Board of Education Rules §§1.1, 14.1, and 14.3, Chapter XIII.

43. District of Columbia Board of Education Rule)18.1, Chapter XIII, which sets forth grounds for exclusion from school, is violative of the right to an equal educational opportunity and, as presently applied, is without statutory authority, insofar as it enables Defendants to exclude plaintiffs entirely from publicly-supported education.

44. The arbitrary application of D.C. Code §31-203, so that children similarly situated to plaintiffs in all material respects are provided special instruction or other publicly-supported education while plaintiffs are denied any publicly-supported education, also denies plaintiffs' right to an equal educational opportunity.

SECOND CLAIM FOR RELIEF: FAIR PROCEDURES

45. In addition, the procedures by which plaintiffs and other children are excluded, suspended, expelled, reassigned or transferred from regular public school classes violate their rights to due process of law, in that there is neither a prior hearing nor a periodic review of their status.

46. Specifically, plaintiffs and other children in the class they represent are denied their constitutional rights to be informed in writing of the reasons for their exclusion, suspension, expulsion, or transfer; to receive a prior hearing, such hearing to be conducted by an impartial arbiter of fact and law or applicable rule, to confront witnesses, to have access to school records, to present evidence and witnesses in their behalf, to be represented by counsel or other advocate of their choice; and, to a review by an appropriate body, such as the Board of Education.

47. Board Rule § 18.1, Chapter XIII, which sets forth grounds for exclusion from school, on its face and as applied, is void for vagueness, and is the subject of such indefinite, arbitrary and capricious abuse, that it violates plaintiffs' constitutional right to due process of law.

48. Plaintiffs are also denied their right to have alternative education made available to them pending and following the outcome of any such proceeding concerning suspension, exclusion, expulsion or transfer from regular classes, or pending any assessment of their need for special education.

THIRD CLAIM FOR RELIEF: FAILURE TO PROVIDE WARDS OF THE DISTRICT OF COLUMBIA WITH REGULAR INSTRUCTION

49. By failing to enroll and to provide plaintiffs who are wards of the District of Columbia with programs of publicly-supported education, Defendants further violate these plaintiff children's rights guaranteed to them by the United States Constitution, Amendment V, and D.C. Code § 31-201. Defendants of the Social Services Administration of the District of Columbia Department of Human Resources, as guardians to plaintiffs Mills and Blacksheare, dependent wards of the District of Columbia, have failed to discharge their duty to cause such children to be regularly instructed in public or private schools.

50. Specifically, Defendants Thompson, DeLaine, Randall, and Rutledge, and their agents, have failed to enroll plaintiff Mills, a dependent committed ward, and other dependent children resident at Junior Village, in or provide them with programs of publicly-supported education for substantial periods of time.

51. Furthermore, Defendants Thompson and Rutledge have failed to enroll plaintiff Blacksheare, a dependent committed ward, in or provide him with a program of publicly-supported education for a substantial period of time.

IRREPARABLE HARM

52. Defendants' actions excluding plaintiffs from all publicly-supported education, including the educational services to which they are entitled by the constitutional guarantee of equal educational opportunity, cause plaintiffs to suffer continuing and irreparable harm to their future as students, wage-earners, citizens and members of society.

53. The stigma which attaches to plaintiff children by reason of Defendants' actions constitutes irreparable harm.

54. Defendants' actions create a "self-fulfilling prophecy," *Hobson* v. *Hansen*, 269 F. Supp. 401, 491 (D.C. 1967), propelling these plaintiff children toward academic, social and economic failure.

55. Unless Defendants immediately provide publicly-supported education to plaintiffs, these children will suffer a further cumulative deprivation of their declared constitutional and statutory rights to a publicly-supported education.

WHEREFORE, plaintiffs respectfully pray that this Court:

1. Declare that Defendants' Rules, policies and practices which exclude children from a regular public school assignment without providing (a) adequate and immediate alternative educational services, including, but not limited to, special education or tuition grants, and (b) a constitutionally adequate prior hearing and periodic review of their status, progress and the adequacy of any educational alternative, deny plaintiff children due process of law and equal protection under the law in accordance with the Fifth Amendment of the United States Constitution.

2. Enjoin Defendants from continuing their policies and practices which exclude children from a regular public school assignment without providing (a) adequate and immediate alternative educational services, including, but not limited to, special education or tuition grants, and (b) a constitutionally adequate prior hearing and periodic review of their status, progress and the adequacy of any educational alternative.

3. Enjoin Defendants from failing to:

a. Provide plaintiffs, and all members of the class they represent, with a publicly-supported education within thirty days of the entry of its Order;

b. Submit, within fourteen days of the entry of its Order, a report to this Court and counsel for plaintiffs, which shall list each child presently suspended, expelled, or otherwise excluded from a publicly-supported education, the reason for, and the date and length of, each such suspension, expulsion, or exclusion and the proposed time and type of educational placement of each such child;

c. Notify, within forty-eight hours of the submission of said report, the parents or guardian of each such child, and inform each as to the child's right to a publicly-supported education and as to that child's proposed educational placement;

d. Cause to be publicly announced, within twenty days of the entry of its Order, to all parents in the District of Columbia that all children, regardless of handicap or other disability, have a right to an education; and to inform such parents of the procedures required to enroll their children in an appropriate program; and to submit a plan to the Court and counsel for plaintiffs for future periodic announcements.

e. Hold constitutionally adequate hearings before a master or other appropriate person, to be appointed by the Court, for any member of plaintiff class who feels aggrieved by his subsequent educational placement. Such master or other person shall:

(1) Set forth the bases for the proposed assignment or reassignment and provision of interim or special educational services;

(2) Provide an opportunity to each child (a) to receive a medical and psychological examination; and (b) to be represented by an advocate of his own choice and to present evidence presented by school officials or their witnesses;

(3) Determine any appropriate assignment or reassignment; and

(4) Review periodically, at intervals to be set by this Court, any action resulting from his determination, by this same procedure.

f. Provide plaintiffs compensatory services to overcome the effects of any past wrongful exclusion.

g. Expunge or correct the school records of plaintiffs with respect to the reasons for any past wrongful suspensions or exclusions and to reflect the lack of procedures surrounding such suspensions or exclusions.

h. Submit to the Court, within thirty days from the time of the entry of its order, a plan for adequate hearing procedures to precede any (1) refusal to admit a child to a regular public school assignment; or (2) any reassignment or transfer of a child from a regular public school assignment; and (3) for adequate review of such decisions, including the alternative education provided.

i. Submit to the Court, within thirty days from the entry of its Order, a plan for adequate hearing procedures to precede any suspension of a pupil from school, such plan to include provisions for (1) defining the specific authority granted to school personnel to suspend and the limitations imposed on that authority, (2) the re-requirement of alternative education for any period of suspension in excess of two consecutive full school days, (3) the specific grounds upon which a child may be suspended, (4) written and specific notice to parents or guardian of the basis for any proposed suspension, (5) the opportunity for a hearing on any suspension, with representation by counsel, confrontation of witnesses, rebuttal of evidence, presentation of evidence in behalf of the child, and access to the school records of the child, and (6) written notice to parents or guardian of the right of the child to a review of any suspension before an impartial tribunal, such as a committee of the Board of Education.

4. Grant such other and further relief as shall be deemed necessary and appropriate, including but not limited to attorneys' fees.

Respectfully submitted.

JULIAN TEPPER,
NLADA National Law Office,
Washington, D.C.
STANLEY HERR,
NLADA National Law Office,
Washington, D.C.
PATRICIA WALD,
Center for Law and Social Policy,
Washington, D.C.
PAUL DIMOND,
Center for Law and Education,
Harvard University,
Cambridge, Massachusetts.

APPENDIX A-1

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, SS:

I, SCOTT S. SURREY, being first duly sworn, depose and say:

1. I reside at 120 Rumsey Court, S.E., Washington, D.C.

2. From October, 1969, through May, 1971, I was employed by the Social Services Administration, Department of Human Resources, as a Social Services Representative. I served at Junior Village, where I had casework responsibility for dependent, committed children.

3. Peter David Mills, age 12, black, and a committed ward of the Social Services Administration, was one of the children for whom I had casework responsibility. All parental rights over Peter were severed when he was one year old, and he has been at Junior Village since July of 1970.

4. Peter has been without a public school program of any kind since his exclusion from the Brent Elementary School, a public school of the District of Columbia, on March 23, 1971.

5. In September of 1970, Peter was enrolled in the Brent Elementary School, from which he was excluded in March of 1971. I received a copy of a letter from the principal of Brent School, Mr. Herbert Boyd, dated March 23, 1971, advising Mrs. Vesta Randall, school liaison officer at Junior Village, that effective that same day, Peter was excluded from further attendacne at the Brent Elementary School because of his disciplinary problems, disrespect, and the school's knowledge of his past misbehavior. To my knowledge, no pre-suspension conference or any other hearing was held by school representatives with Junior Village caseworkers. No alternative educational arrangements were suggested by the Brent School. No time limit was placed on the length of his exclusion, and no diagnostic evaluations or tests were to be scheduled.

6. At the end of March, 1971, I asked the school liaison officer at Junior Village, Mrs. Vesta Randall, to look for another public school for Peter. She promised to look into it. But to the best of my knowledge, no school placement for Peter has been made.

SCOTT S. SURREY.

Subscribed and sworn to before me this 22nd day of September, 1971, in the District of Columbia.

J. AUSTIN,
Notary Public.

My Commission Expires June 30, 1974.

Appendix A–3

AFFIDAVIT

United States of America,
District of Columbia, SS:

I, RONALD V. DELLUMS, being first duly sworn, depose and say:

1. I reside at 1749 North Portal Drive,
Washington, D.C.

2. I am a member of the House of Representatives and of its Committee on the District of Columbia. I am presently serving on its subcommittees for Youth Affairs, Public Health and Public Welfare. I hold a Masters Degree in Social Work from the University of California at Berkeley. Prior to assuming office I have engaged in social work activities on behalf of disadvantaged youth, and I have been concerned with the welfare of dependent children residing in Junior Village.

3. On knowledge and belief, Peter Mills is a committed, dependent ward of the District of Columbia resident at Junior Village; he is without any educational opportunity; and he is without a parental guardian.

4. I join in this complaint as next friend to Peter Mills.

Ronald V. Dellums.

Subscribed and sworn to before me this 23 day of September, 1971, in the District of Columbia.

Aileen M. Foley,
Notary Public.

My commission expires

Appendix A–4

AFFIDAVIT

United States of America,
District of Columbia, SS:

I, FRED TAYLOR, being first duly sworn, depose and say:

1. I reside at 7305 Gordons Road, Falls Church, Virginia.

2. I am a clergyman in the District of Columbia and am Executive Director of FLOC (For the Love of Children, Inc.), 2025 Massachusetts Avenue, N.W., Washington, D.C., an organization whose incorporated purpose is to alleviate the plight of homeless and dependent children in the District of Columbia, as typified by Junior Village. For the past six years, I have been actively engaged in promoting the welfare of children at Junior Village.

3. On knowledge and belief, Peter Mills is a committed, dependent ward of the District of Columbia, resident at Junior Village; he is without any educational opportunity; and he is also without a parental guardian.

4. I join in this complaint as next friend to Peter David Mills.

Rev. Fred Taylor.

Subscribed and sworn to before me this 21 day of September, 1971, in the District of Columbia.

Notary Public.

My commission expires March 31, 19__.

Appendix B

AFFIDAVIT

United States of America,
District of Columbia, ss:

I, EASTER BLACKSHEARE, being first duly sworn, depose and say:

1. I reside at 130 V Street, N.W., Washington, D.C. My thirteen year old son, Duane Blacksheare, resides at Saint Elizabeth's Hospital; he is a dependent ward of the District of Columbia.

2. My son Duane was excluded from public school in the District of Columbia in October of 1967. At that time, he was attending the third grade at Giddings Elementary School. In March, 1971, Duane was placed in the seventh grade at Roper Junior High School.

3. Duane had completed the junior primary, first, and second grades at Van Ness Elementary School prior to his exclusion. He entered the third grade in September of 1967. In October of that year, he was transferred to a small "social adjustment" class at Giddings Elementary School, a D.C. public school. I was not contacted prior to this transfer, nor was I given any reason for it. Duane was simply taken to this new school by a student member of the safety patrol in the middle of a regular school day.

4. Duane remained in the class at Giddings for about five days. One day, he came home and told me that he did not have to go to school anymore.

5. It is my understanding that the social adjustment class's special teacher was not in school the week Duane was at Giddings, and a regular substitute took her place. It was this substitute teacher, a Mrs. Jackson, who told Duane to get out and not to come back anymore. I called the school and was told by one of the office personnel that Duane had been dismissed from school.

6. At the time of Duane's dismissal from Giddings, I received no notice of any plan to suspend him, nor was I called to the school for a conference on the suspension or educational alternatives for my son. I received no written notice of his suspension nor of the reasons for it; no formal hearing was held; and I was not advised of the right to have such a hearing and present spokesmen in Duane's behalf. I was given no indication as to when or how Duane might return to school. Duane's father died on October 17, 1967, but this fact, and its obvious effect on Duane's behavior, was not taken into account by those who were responsible for the decision regarding Duane's exclusion.

7. From October of 1967 through January of 1968, Duane remained at home, without instruction of any kind. No visiting instructor or tutor was assigned to him for that period.

8. In January, 1968, on the suggestion of the Area C Community Mental Health Clinic which Duane had been attended, Duane entered D.C. General Hospital in order to attend a school program there, taught by teachers from the Sharpe Health School. Duane remained in this Area C program until March 10, 1968. At that time, I moved from 1015 12th Street, S.E., in Area C, to my present address in Northwest Washington, which is in Area B. Duane became ineligible for the Area C school program, and there was no comparable program for Area B residents. Doctors who saw Duane while he was at Area C, including a Dr. Weis, diagnosed him as being emotionally disturbed:

9. Upon Duane's leaving Area C in March of 1968 I contacted the Special Education Department of the School Board to find out about an educational alternative for Duane. The School Board sent a visiting home instructor once or twice a week, each time for about forty-five minutes, beginning approximately at the end of April of that year. The instructor continued to come to our home for for individual lessons from September through June of the 1968–1969 school year. Over the course of that year, the number of instruction sessions decreased to about one a week. Often the visiting instructor merely came to the house and talked to me, without offering Duane any academic lessons.

10. In September of 1969, Duane was referred to Saint Elizabeth's Hospital by a psychiatrist at Children's Hospital, where I had taken Duane to the clinic. He was discharged from St. Elizabeth's after only four days, as his doctor, a Dr. Shingle, felt that Duane did not need the kind of treatment offered at the hospital.

11. In November of 1969, Duane entered the DIAL program, a special class at the Perry School, a D.C. public school. Duane was expelled from this class approximately one week later for fighting and causing a disturbance. I received a letter from the Speical Education office, stating that Duane was not ready for the DIAL program. I therefore contacted the Sharpe Health School and then Dr. Stanley Jackson to request another visiting home instructor to compensate for this lack of formal education, but Dr. Jackson denied my request.

12. Duane had previously been placed on the waiting list for Overbrook School, a private residential facility in Virginia. However, I learned that the School Board would not pay for all of the tuition for Overbrook, but could only pay approximately one-third.

13. During the summer of 1970, William Raspberry of *The Washington Post*, after writing a feature article about Duane and the plight of other children needing special education in the District, contacted Mrs. Lindo at the Department of Special Education. She had been in charge of Duane's file for some time. However,

even though Mr. Whitt at the Overbrook School had told me Duane could be accepted if the tuition were paid, Mrs. Lindo did not succeed in arranging a tuition grant for Duane.

14. In May, 1970, I filed a Beyond Control complaint on Duane in the D.C. Juvenile Court, so that he would be enrolled in a suitable school program. On November 16, 1970, Duane was made a ward of the Social Services Administration, with the Court ordering that Duane be provided an education at Overbrook. Unknown to the Court, the residential section of Overbrook was closed at about that time. Nonetheless, Duane was committed to SSA as a dependent child and was sent to Junior Village to await transfer to Overbrook. At Junior Village, Duane ran away and came home twice within four days of his arrival there, because of sexual assaults by other boys at Junior Village. On November 20, 1970, Duane was sent to Cedar Knoll because of his abscondances from Junior Village. We had returned to Court and Judge Goodrich had ordered him transferred to Maple Glen, but when I went to visit, I found that he was at Cedar Knoll instead. Duane remained at Cedar Knoll for about one week. He was then transferred to Oak Hill, for fear he might run away, even though, to my knowledge, he had made no attempts to run away from Cedar Knoll. The windows at Oak Hill have prisonlike bars, and the campus is surrounded by barbed-wire fences. Duane was kept in isolation for sixteen hours a day at Oak Hill. After Christmas, he was returned to Cedar Knoll, where he finally was placed in a school program at that institution.

15. In February of 1971, I returned to Juvenile Court and requested that Duane be allowed to return home. This request was granted, and Duane has been at home since late February.

16. A few days after Duane's return home, I visited the Special Education office of the D.C. School Board to try to make some appropriate arrangements for Duane's continuing education. An article detailing Duane's lack of schooling had appeared in the *Washington Star* a few days earlier. Without conducting an evaluation or diagnostic interview of any kind, Mr. Queen, of the Special Education Department, placed Duane in a seventh grade class at Roper Junior High. These arrangements were made the same day as my visit to Mr. Queen's office. Roper is approximately one hour's distrance by bus from our home.

17. Duane completed the school year at Roper Junior High School. He received no marks and was not enrolled in any specific grade for the following year.

18. On July 13, 1971, Duane entered D.C. General Hospital on a voluntary basis for medical care and counseling. He indicated to me that he wanted to go to St. Elizabeth's Hospital so that he could return to school as soon as possible.

19. On September 10, 1971, Duane was transferred to St. Elizabeth's Hospital. Here he is just sitting around doing nothing. He has no schooling of any kind. During the summer, Duane returned home for weekend visits, and his behavior was excellent. He has told me many times that all he wants to do is go back to school. Duane says, "My nine year old sister knows more than I do."

20. Duane needs a classroom where he can learn. He needs it now.

EASTER BLACKSHERE.

Subscribed and sworn to before me this 21st day of September, 1971, in the District of Columbia.

Notary Public.

My Commission Expires July 14, 1976.

APPENDIX C

AFFIDAVIT

UNITED STATES OF AMERICA
District of Columbia, ss:

I, DAISY LIDDELL, being first duly sworn, depose and say:

1. I reside at 601 Morton Street, N.W., Washington, D.C., with my son, George Liddell, Jr. George is eight years old and receives AFDC benefits.

2. My son has never attended public school. In July of 1970, his application for admission to the Maury Elementary School was rejected. No substitute educational arrangements were made for George, and he has never even had any visiting home instruction.

3. At Maury Elementary School, I was told by the counselor who assisted me with the application that there was no special classroom for a "slow" child like George. Consequently, his application was sent to Mrs. Lindo, at the Special Education Department of the Board of Education in July, 1970. At about the same time, George was tested by Dr. Rose at Center #1, 1106 Bladensburg Road,

N.E., who told me that George was able to learn and could attend a special class. However, he was not accepted for school. Mrs. Lindo told me that George was on a waiting list for a small special classroom in the public schools, but this has never come through.

4. No tuition grant was given to me by the Board of Education so George could attend a private school. No tutor has come to visit George at home. He has never received any books.

5. In September, 1970, I enrolled George in the Recreation Department program at Roper Junior High, so he would have something to do. There is no formal education in this program, no books, and no homework; George spends most of the time painting and playing games, rather than receiving the special education and training he needs.

6. In April of 1971, I once again attempted to arrange public schooling for George and applied to Lovejoy Elementary School for his admission next September. The counselor who assisted me, Mrs. Marilyn Kareach, told me the school had no special education classes for retarded children, and that George could not be accepted.

7. I have continued to call Mrs. Lindo at the Special Education Department, and the Superintendant's office, but each time, they simply tell me that George is still on the waiting list, and that there are several hundred children like him who are also waiting for a place in a school classroom. Many times Mrs. Lindo has not even returned my telephone calls.

8. George is now eight years old, and he is still waiting for a school. I do not have the money to send George to a private school. If other children can go to school, why cannot a child like George, who is retarded, but able and willing to learn? How will George take care of himself when he grows up if he is not given a chance to attend school and learn?

MRS. DAISY LIDDELL.

Subscribed and sworn to before me this 28 day of May 1971.

BETTY M. SMITH,
Notary Public.

My commission expires Sept. 30, 1973.

APPENDIX D

AFFIDAVIT

UNITED STATES OF AMERICA
District of Columbia, ss:

I, INA GASTON, being first duly sworn, depose and say:

1. I reside at 714 9th Street, N.E., Washington, D.C., with my eight year old son, Steven Gaston.

2. Steven has not attended public school in the District of Columbia since September, 1969, due to his exclusion from his first grade class and, previously, from kndergarten. He is not receiving any publicly supported education at this time.

3. In September, 1969, Steven was enrolled in the first grade at Taylor Elementary School. After three days, his teacher called and asked me to take Steven home. She said that she could not cope with him because he refused to stay in his seat, but instead, wandered about the classroom. No conference was held to discuss this matter. I received no formal notification of my son's dismissal from school. I had no opportunity to appeal the action. No alternative educational arrangements were made or even discussed. No assistance was offered or suggestions made as to how best to deal with Steven or determine if his inability to sit still was the result of a physical or emotional problem. No tutor or visiting home instruction of any kind was made available to my son.

4. During the summer of 1970, I met five or six times with Miss Lougee, a liaison between the public schools and the Area C Community Mental Health Center, to discuss Steven's problems. She arranged for Steven to take a battery of tests at Area C in October, but was of no further help to me. After Steven was tested, Dr. Standish told me that Steven is slightly brain-damaged and hyperactive. Steven attended the Area C school program for approximately one month in October, 1970, but still had trouble sitting still, so Dr. Standish suggested that Steven enter the Contemporary School, a school for exceptional children located in Virginia.

5. After interviewing Steven in October of 1970, the Contemporary School agreed to accept him at any time during the 1970-1971 school year, provided that the tuition was paid in full.

6. In October of 1970, I contacted Miss Lindo at the Special Education Department of the School Board, and submitted to her my written application for a tuition grant for Steven. When I called her one month later, I learned that my son would be placed on a waiting list for the financial aid that could have enabled him to attend the Contemporary School. Miss Lindo said she would let me know when the money was available. She still has not done so.

7. My husband and I cannot afford the full cost of tuition at the Contemporary School, and the D.C. public school system refuses to assign Steven to a classroom. Therefore, he has remained at home, receiving no education, since his exclusion in September of 1969. Steven spends his time playing aimlessly. He has no friends, since other children his age are in school all day.

8. Steven is capable of learning. It seems to me that the Board of Education should, therefore, provide either the classroom or the funds necessary for him to do so. Steven is losing out on whatever chance he has to become a useful, happy person. He is alone, separated from other children his age, and denied an experience each child should have—the opportunity to develop his full potential. Steven deserves that chance.

Mrs. INA GASTON.

Subscribed and sworn to before me this 7th day of June, 1971.

______ ______
Notary Public.

My commission expires July 14, 1971.

APPENDIX E

AFFIDAVIT

UNITED STATES OF AMERICA
District of Columbia, ss:

I, MARVA WILLIAMS, being first duly sworn, depose and say:

1. I reside at 641 Condon Terrace, S.E., Washington, D.C., in a public housing project of the National Capitol Housing Authority.

2. My son, Michael Anthony Williams, age 16, has not attended public school in the District of Columbia since October, 1969, as a result of his exclusion from the Sharpe Health School. Michael is an epileptic and is also slightly retarded. He is not enrolled in any school program at this time.

3. Michael attended Hart Junior High School during 1968–69, repeating the seventh grade. With school opening in September, 1969, he was suddenly transferred to Sharpe Health School. This transfer was made without my prior knowledge or consent. I was given no explanation of this transfer.

4. In September of 1969, after being at Sharpe for about one month, Michael had a seizure and fell down, breaking some teeth. The school took him to the hospital. He was brought first to Children's Hospital, then to George Washington University Hospital, and finally was admitted to St. Elizabeth's Hospital for a period of observation. Mr. Parker, the principal of the Sharpe Health School, told me that Michael could return to class whenever the doctor said he was ready. Michael was released from St. Elizabeth's at the end of December, 1969. I subsequently contacted Mr. Parker to tell him that the doctor felt Michael could return to school. At this point, Mr. Parker told me that Michael should not return to school because he had missed too much but instead, should remain at home until the following September.

5. No conference was held concerning Michael's exclusion from school. I received no formal notice of Michael's exclusion nor of the reason for it. I was not advised of any right to appeal this decision or to present any witnesses in my son's behalf.

6. I asked Mr. Parker, the school principal, to arrange for Michael to have a tutor visit him at home. None was granted.

7. No alternative educational arrangements were made for Michael at the time of his exclusion. Mr. Parker told me that he would try to have Michael accepted at the National Children's Rehabilitation Center in Leesburg, Virginia.

8. In the summer of 1970, I contacted Sharpe Health School to arrange for my son to return to school in September, as Mr. Parker had suggested. Once again, I was told that Michael could not return to Sharpe, but instead should go to

Leesburg. However, Mr. Parker could not tell me definitely that Michael would be admitted to Leesburg. I therefore contacted Miss Lindo at the Department of Special Education.

9. Miss Lindo informed me that she had never been advised by Mr. Parker of Michael's need. She obtained his records from Sharpe. I applied for a tuition grant, so that Michael could attend Leesburg, and was told by Miss Lindo that Michael would be placed on the waiting list for a grant. This was in the summer of 1970. Michael is still on the waiting list.

10. In November, 1970, I received a letter from the National Childrens Rehabilitation Center in Leesburg, stating that Michael could not be accepted because they did not have vocational training, and testing had indicated that this would be the best program for Michael. I therefore called Miss Lindo to inform her of this letter, and she told me that Michael had been rejected only because I was unable to pay the tuition, and that as soon as a tuition grant was approved for him, he would be accepted at Leesburg.

11. Michael has received no public school education since October, 1969. He has not had any visiting home instruction. He has not been granted any monies for tuition at a private school.

12. Following his exclusion from school, Michael remained at home, and attended a day-care program at St. Elizabeth's Hospital. However, this program did not adequately occupy Michael during the hours when I was at work, and because of his seizures, he could not be left unsupervised. Therefore, Michael was voluntarily admitted to St. Elizabeth's Hospital in December, 1970, for purposes of education and medical support. At. St. Elizabeth's however, Michael has had no education program since March 1971.

13. Michael's doctor has written several recommendations supporting Michael's admission to a school program and would do so in the future. Testing administered at the hospital indicated that Michael has higher potential than presently exhibited. As soon as I have a school program for Michael, I will take him from the hospital. He has no physical or mental condition which necessitates hospitalization. Michael is just waiting for a school that can offer the personal attention he so badly needs. How long must he wait?

MARVA WILLIAMS.

Subscribed and sworn to before me this 1st day of June, 1971.

BETTY N. SMITH.
Notary Public.

My commission expires Sept. 30, 1973.

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss:

The undersigned, Andrew Leonard King, being duly sworn, deposes and says:

1. I presently reside at 233 Anacostia Avenue, N.E., Washington, D.C. 20019.

2. I am a teacher at Towsen State College in Baltimore, Maryland.

3. My wife, Ruth, is a life-long resident of the District of Columbia, and I have made the District my home for the past 30 years. We have two children: Robyn L. King, 22, and Janice Ruth King, 13, his sister.

4. Until the age of 14 months, Janice Ruth had developed as a "normal" child. At that age, however, she suffered a severe illness, characterized by convulsions and a loss of general mobility. Subsequently, Janice Ruth developed a right hemiplegia. As Janice developed toward school age, it was apparent that she had sustained brain damage. She was not able, therefore, to pass certain child-development milestones such as independent toilet use, development of language patterns, or the acquisition of self-feeding skills

5. From 1960 to 1963 Janice Ruth attended the pre-school program at the D.C. Society for Crippled children. For whatever help this program might have continued to be, it was not available to Janice once she reached beginning school age. We could not find a private placement we could afford for Janice.

6. In 1964, as Janice Ruth had reached beginning school age, I went to the Director of Special Education in D.C.—at that time, the Director was Rosa Jones. Without consulting any medical records (or actually seeing Janice Ruth) the Director determined that the only "program" available for Janice's education would be institutionalization at Laurel, the District Training School.

7. Later in the same year, my wife suffered a stroke, and under the circumstances we reluctantly found it necessary to commit Janice Ruth to Laurel. She

remained there for a year, coming home every weekend from Thursday until Monday. Once in December of 1965, when I went to Laurel to pick up Janice Ruth, I noticed that she had a black eye. While waiting for her another time during that same month, I heard her screaming. It turned out that two of her front teeth had been knocked out and she had another black eye. In addition, her buttocks were blistered and bruised. I brought Janice Ruth home from Laurel for good.

8. Janice Ruth has remained home since 1965. My wife and I have done what we can to realize Janice's learning potential. Yet neither of us possess the educational expertise which could best serve Janice's most acute learning needs. In addition to providing parental love in an environment of warmth, and teaching Janice Ruth as best we can, we have tried repeatedly to enlist the aid of the District School System. For example, in 1967, I contacted the new Director of Special Education, Stanley Jackson, with the same plea that had been turned down by his predecessor. Again, Janice Ruth was rejected.

Once again, this spring I have contacted the Department of Special Education with yet another request for some form of relevant public education for my daughter. This application—the same that was rejected in 1965 and 1967—is currently "pending."

9. Janice Ruth's present physical and mental state cause me to be hopeful. Those unfamiliar with the realities of the life of a multiply-handicapped individual might well despair of Janice's need for a wheelchair, or her dependence on aid in eating and tending to her toilet needs, or her lack of even rudimentary language patterns. But I see my daughter respond to familiar music and listen with curiosity (and, I think, some sense of understanding) to conversations in her presence. It is this potential that gives me hope that she can be trained to talk, take care of herself, and socialize with other children. But I feel that as Janice Ruth grows older, that hope will corrode to despair if her potential is not developed. She is now 13 and has received no formal training since she was 7, and I am afraid that time is running out.

ANDREW LEONARD KING.

Subscribed and sworn to before me this 31 day of May 1971.

ANNE PALLIE,
Notary Public.

My Commission Expires Jan. 15, 1976.

APPENDIX G

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss:

The undersigned, Mary M. James, being duly sworn, deposes and says:

1. I presently reside at 2512 Ontario Road, N.W., Washington, D.C.

2. Although I have worked as a nurse for some years, I can no longer do so. I now receive welfare benefits under the Aid to Families with Dependent Children program.

3. I have five children; three of them are married, and two, Jerome, 12, and Theresa, 9—are still living at home.

4. Jerome has been a difficult problem. I have to stay home most of the time to take care of Jerome who has never been enrolled in school. I now earn some money taking care part-time of another retarded child.

5. Jerome seemed normal at birth, but when he was about 10 months old, I noticed that he seemed not to respond to things around him (T.V., his sister, etc.).

6. The doctor, who examined Jerome at Johns Hopkins, Dr. Whitehouse, could not be sure first what caused this condition that developed into retardedness. It is possible that he ate some lime poison (this was reported by a babysitter). Also he had a fall on his head at three months; but its effect is not clear.

7. As he approached school age, I tried to get him into some program of education that would deal with his specific needs. When I applied to Laurel, the District Training School, a Mrs. Still placed Jerome on the "waiting list" but this led to nothing. At this time Jerome's case was screened at D.C. General Hospital. Later I called on the National Children's Center, but they, too, were unable to accommodate Jerome. Last year, through the Morgan School, I applied for a tuition grant from the Department of Special Education. Mrs. Lindo, the super-

visor of the Department, told me that no funds were available. This spring I re-applied to that program; as it stands now Jerome has not received any definite placement for this school year.

8. Jerome's present condition is encouraging in some ways, but he needs the opportunity to learn some basic skills that could make his life happier and more whole. Jerome walks quite well. Although he has no real vocabulary, he makes his wants known by verbal sounds. Jerome also listens when people talk to him. He has learned to feed himself with his hands. I have worked very hard with Jerome on the toilet training and he is now partially toilet-trained. He needs more help with this. He cannot dress himself alone but has learned to help when he is being dressed.

9. Jerome remains at home. He has only his sister and other retarded children to play with. He needs some exposure to a social situation, and he needs special educational training. I need help in helping him.

MARY M. JAMES.

Subscribed and sworn to before me this 23 day of July, 1971, in the District of Columbia.

______ ______.

My commission Expires Jan. 15, 1973. *Notary Public*

APPENDIX H

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss

I, NONA M. FLYNN, being first duly sworn, depose and say:

1. I reside at 7223 Van Ness Court, McLean, Virginia.

2. I am presently employed as Coordinator of the Child Study Center, Department of Special Education, The George Washington University, and am a doctoral candidate in the field of special education.

3. I have received my M.A. degree from The George Washington University. My work experience in the field of special education has included the following positions: coordinator of educational research studies with physically handicapped children at Cybernetics Research Institute, Washington, D.C.; teacher of special classes of children of migrant workers in LaGrange, Texas; director of a tutoring program for Chirst Child Settlement House, Washington, D.C.; and diagnostic-prescriptive teacher, Prince William's County.

4. On March 19, 1971, I conducted an educational evaluation of Duane Blacksheare, at the Child Study Center, The George Washington University.

5. It is my professional opinion that Duane Blacksheare can profit from an education.

6. Duane visited the Child Study Center with his mother for a one-hour evaluation period. He was eager to discuss his present placement at Roper Junior High and displayed no signs of uneasiness or shyness during the interview. In the two week period preceding the interview Duane's lunch money was taken from him several times and he was threatened by several groups of boys. He stated that he could "take care of them" but would not fight at school anymore because he was not going to be "kicked out again for fighting."

7. Duane expresses a strong desire to remain in school but is also very much threatened by the present situation at Roper. He has been instructed by the assistant principal not to talk about his background to his teachers or peers, and no supportive services have been arranged. Roper Junior High is approximately a one-hour bus ride from his home.

8. Duane's reading ability is difficult to assess accurately. Functionally, he is reading on a first grade level. However, he appeared to recall words more readily toward the end of the passage assigned. He apparently has done little or no reading geared to his general level in a long time. With intensive review I would expect his reading level to jump at least to a second grade level in a short period of time.

9. His mastery of the basic math skills is very limited. He remembered the mechanics of addition and subtraction but reverted to counting with his fingers to work problems.

10. Duane is functioning on an elementary level academically. Prior to placement, a special program should be carefully worked out with his teachers and ancillary services at a school within a reasonable transportation distance from Duane's home. The school counselor would see him on a weekly basis and stay in close touch with his teachers.

11. At this time Duane is severely *academically* retarded due to a variety of circumstances resulting in lack of consistent and prolonged instruction for approximately three and one-half years. He seems eager and receptive to continuing his education at this time, and appropriate arrangements should be made as quickly as possible to prevent further academic retardation and emotional handicaps.

NONA M. FLYNN.
Notary Public.

Subscribed and sworn to before me this 4 day of June, 1971.
My commission expires January 26, 1974.

APPENDIX I

AFFIDAVIT

COUNTY OF FAIRFAX,
State of Virginia, ss.

I, NONA M. FLYNN, being first duly sworn, depose and say:

1. I reside at 7223 Van Ness Court, McLean, Virginia.

2. I am presently Coordinator of the Child Study Center, Department of Special Education, The George Washington University. I am a candidate for a doctoral degree in Special Education.

3. I received my M.A. degree in Special Education from The George Washington University, and have had experience as a diagnostic-prescriptive teacher, coordinator of educational research projects, and director of tutoring programs.

4. George Liddell visited the Child Study Center on July 14, 1971, for an educational evaluation. It is my professional opinion that George can profit from an education.

5. When requested to draw a picture, George responded readily and drew a series of scrawls, some of the circular type—a drawing typical of a three to four year old child. George cannot write his name and in general displays a lack of fine motor coordination skills. His gross motor control is developed to the degree that he moves about readily, jumps, runs, and catches and throws a large ball.

6. Two-piece puzzles, each with colored pictures of familiar objects, were presented, singly and then several at a time. George put the two pieces of one puzzle together successfully and usually could name the object. When two or three puzzles were placed in front of him he displayed difficulty selecting the matches, failing to use color and shape cues. With a little prompting he did, however, pick up the patterns and complete the tasks, showing much pleasure in his accomplishment.

7. George has an understanding of number concepts through four and is able to rote count through eleven with encouragement. He showed no isolated letter recognition and has no sight vocabulary.

8. His visual and auditory perception seem adequate on the basis of the preliminary testing. Further exploration is needed for a full evaluation.

9. Educationally, George is functioning on the level of a four year old child. However, he displayed an eagerness to perform, a long attention span and responded well to direction. These indicate that George is capable of learning more skills than he presently displays. His mother reported that George has never been in any type of school setting.

10. The overall picture would indicate a trainable (or severe) mentally retarded class placement for George. If he is to develop the basic skills necessary for independent functioning in society it is imperative that he be placed in a classroom *learning* environment without further delay.

NONA M. FLYNN.

Subscribed and sworn to before me this 20th day of July, 1971.

Notary Public.

My Commission Expires January 26, 1974.

APPENDIX J

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss:

I, SUE C. TENORIO, being first duly sworn, depose and say:

1. I reside at 2900 South Glebe Road, Arlington, Virginia.

2. I am presently affiliated with the Department of Special Education of The George Washington University, where I am a candidate for a doctoral degree in Special Education.

3. I have received my B.S., M.Ed., and Ed.S. degrees in Special Education, and have had experience as a classroom teacher of emotionally disturbed children, an educational consultant, a supervisor of special education teachers, and a university instructor and guest lecturer. Professional articles have been published at the local, state, and national levels.

4. On June 9, 1971, Steven Gaston visited the Child Study Center of The George Washington University for an educational evaluation.

5. Stephen appears to be a child who is greatly in need of an educational program that would not only help him to develop his skills and abilities but also provide him with some structure and consistency.

6. Stephen presents himself as a rather pleasant but shy, socially immature child. His difficulty in being able to relate meaningfully to others would appear to be a direct result of not having the opportunity to take advantage of the positive effects of interaction with his age-mates. The longer he is denied this opportunity, the more severe his difficulties of interpersonal interaction become.

7. Stephen can and did respond to simple directions during the evaluation. He seems to respond best to clear-cut limits with positive reinforcement of appropriate behavior(s).

8. I strongly urge that Stephen Gaston be placed as early as possible in a publicly supported educational program which utilizes a contingency management approach in a small-group setting.

SUE C. TENORIO.

Subscribed and sworn to this 9th day of June, 1971.

KATHERINE F. ARANWICA,
Notary Public, District of Columbia.

My Commission Expires June 14, 1972.

APPENDIX K

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss:

I, ROBERT W. PROUTY, being first duly sworn, depose and say:

1. I reside at 5216 Light Street, North Springfield, Virginia 22151.

2. I am presently Assistant Professor of Special Education and Coordinator of the Diagnostic-Prescriptive Teacher Program, Department of Special Education, at The George Washington University.

3. I am a doctoral candidate in the field of Special Education at Syracuse University. I received my B.S. degree in elementary education and education of the mentally retarded at the State University of New York at Geneseo, in 1960, and an M.S. degree from Syracuse University in 1961 in the field of mental retardation. I have held a variety of teaching and consulting positions in the fields of retardation and education, and have been published in a number of professional journals. Professional affiliations include memberships in the American Association of University Professors, Council for Exceptional Children, and Phi Delta Kappa.

4. It is widely accepted among educators that all children must be provided with education and training during their formative years to enable them to function effectively as adequate and productive members of society. Severe and irreparable harm is likely to result from the prolonged denial of such educational opportunities to these petitioning children. Exclusion of such children from school without providing an adequate alternative educational opportunity inflicts upon them not only the immediate punishment of separation from their peers and removal from those experiences calculated to be of most immediate value to them educationally, but also endangers their subsequent capacity to function as effective citizens and adequate human beings.

5. There exist in the District of Columbia a number of educational models and strategies whereby many children, heretofore denied educational opportunity as described above, can be afforded such education and training, often within regular class settings with appropriate support services.

6. These support services include Diagnostic/Prescriptive Teacher and Crisis/Resource Teacher programs, a small number of each exist in the public schools of the District of Columbia. Such services consist of one or more specially trained teacher, based in a regular elementary or junior high school, whose primary role is to determine the educational environments and provisions most conducive to the success of children posing learning and/or behavior problems, and of recommending and, where appropriate, demonstrating such educational modifications as may be

necessary in a regular classroom to facilitate the maintenance and success of such children within their respective regular classes. The rationale for such services is that many children are often unnecessarily removed from regular class settings due to the absence of suitable and appropriate teaching-learning environments within those rooms for such children when, in fact, modifications are feasible to accommodate them. It is my opinion that many excluded children such as Gregory Jones can be satisfactorily provided for in regular class settings with adequate support services such as a Crisis/Resource Teacher or Diagnostic/Prescriptive Teacher.

7. A number of the District of Columbia educationally disadvantaged children are now provided with educational opportunity in the company of their peers through the use of regular school-based consultant services of a variety of models, including those briefly described above.

8. The absence of adequate numbers of such support services contributes to the inability of many District public schools to successfully provide for a sufficiently broad range of children having differing learning and behavior styles. While such services are not a panacea for school problems they do offer a useful resource to teachers and provide many children with an alternative to exclusion from class and school.

9. Peremptory suspension of a child should, by its very nature, lead to a full and prompt analysis by school authorities of both the child and his educational setting, with the primary purpose of determining and providing for his educational needs. Denial of educational opportunity at a point where clear need for improved educational experiences are evidenced constitutes punitive rather than rehabilitative action.

10. To a significant degree, equality of educational opportunity is denied to children who do not have access to such support services available to children in other schools within this school district because of the neighborhood in which they live and chance school assignment. The absence of these services often directly contributes to the exclusion of such children from the public education which society has deemed a necessity.

11. The exclusion of children without prompt and full hearings leading to immediate provision of suitable educational opportunity results in damage, often irreparable, not only to the children and families involved but also to the common good of the society. The point cannot be too strongly emphasized that such action as the arbitrary and prolonged exclusion of petitioner children cannot be justified on the basis of any lack of the existence of suitable educational alternatives. The state of the art in education, while indeed imperfect, provides ample alternative means of providing services to children with learning and/or behavior problems, as well as for modification of class settings not sufficiently responsive to individual needs.

ROBERT W. PROUTY.

Subscribed and sworn to before me this 19th day of July, 1971

D.C. VARNEDO,
Notary Public.

My Commission expires July 31, 1973.

APPENDIX L

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, SS:

I, ROBERT L. BOSTICK, being first duly sworn, depose and say:

1. I reside at 1428 Whittier Street, N.W., Washington, D.C.

2. I am employed by the Library of Congress as a visual information specialist.

3. During the past eighteen years, I have been actively engaged in activities to enhance the educational opportunities for the handicapped children of the District of Columbia within the public school system. My wife and I are parents of a mildly retarded daughter, Barbara Ann Bostick, now twenty three years old. I have been a member of Help for Retarded Children, Inc., which is the D.C. Chapter of the National Association for Retarded Children, for the past seventeen or eighteen years, and a member of its Board of Directors since 1956. I am also a charter member of Concerned Citizens for Exceptional Children, an "umbrella" group consisting of several organizations representing the interests of children of all handicapping conditions. I am a member of School Superintendent Hugh Scott's Task Force on Special Education. I recently joined D.C. Federation No. 524 of the Council for Exceptional Children.

4. It is my firm belief that all children, including the handicapped, have a right to a public school education, and that each child should be accorded the proper resources to develop to his highest potential. I hold the concomitant belief that the D.C. public schools should not be allowed to excuse any child from attending public schools because of any degree of handicapping condition. If the schools have no special educational program or facilities to serve a particular child or group of children, it is the duty of the public school system to provide private school education until such time as the District of Columbia public schools can provide these services. The entire cost of attending a private facility in these circumstances should be borne by the District of Columbia, including the cost of transportation to and from school. The primary responsibility for locating adequate private schools under this tuition grant program should be that of the public school system and not of the parents or guardians of the child.

5. Many parents (including myself), educators, psychologists, and other professional persons firmly believe that the testing and identification procedures presently used by the public school system are wholly inadequate. Many children have received little or no professional clinical or eucational diagnosis, and countless others have been misdiagnosed, misplaced, or recommended for placement in programs totally unsuited to their needs. Thousands of Washington's school age exceptional children have never been seen by school authorities.

6. The public school system should utilize the services of other institutions, such as the area's universities, Children's Hospital, and other diagnostic teams, to assist in the mammoth task of properly identifying the educational needs of all these children.

7. Under the present method of testing, hundreds of youngsters have been placed on waiting lists, either for public school classes or for tuition grants to private schools. Some of these children have been waiting for years. Such treatment is the equivalent of "excusing" a child indefinitely from his right to an education. This practice must be ended. The public schools must be provided with the proper resources and funds to insure that no handicapped child has to wait one day to enjoy the right to an education which is accorded as a matter of course to other children.

8. It is tragic that in the Capitol of the richest nation on earth, at the beginning of the current school year (1970–1971), more than five hundred "trainable" mentally retarded (TMR) children and some one hundred and thirty children with specific learning disabilities (CSLD), to name just two categories of exceptional children, had been certified by school officials as requiring special classes within the public schools, or tuition grants to private schools, However, these children were all placed on waiting lists, and are losing their best learning years.

9. The public schools list no educable mentally retarded on their roster. This is not because there are no educable mentally retarded children, but because the D.C. school administration in 1967, after Judge Wright's decree in *Hobson v. Hansen,* took the unusual step of assigning all of these children to homeroom classes with normal children, and later instituted the MIND program as an attempt to provide for their special learning needs. I sympathize with the new approach of keeping exceptional children in the educational mainstream with their normal colleagues. However, as many parents and teachers can testify, some of these children do not swim when plunged into the mainstream; they drown. Until classification of children according to their disabilities can be abolished, and until classroom teachers are equipped to teach *all* children, the public schools must provide separate homerooms for handicapped children.

10. My wife and I have endured many frustrating and bitter experiences in our efforts to secure an education for our daughter within the D.C. public school system. Our experiences began in July of 1954, when the Board of Education "temporarily excused" Barbara from attending public school on the basis of the wholly inadequate and perfunctory "psychological test" given by a school psychologist, which "showed" that Barbara would not "profit" from attending public schools. Later, in the fall of 1970, sixteen years after this exclusion, Barbara was hired as a full-time education aide (teacher aide) in the Special Education Department of this same District of Columbia public school system. Barbara was "diagnosed" as severely mentally retarded by public school authorities based on the "psychological test" of 1954. It was only through the intervention of a sympathetic and understanding School Board member, Dr. Margaret Just Butcher, that Barbara was enrolled in a special class at the Military Road School in the fall of 1955.

11. Not all excluded children are so fortunate as Barbara in having their diagnoses reviewed and additional education provided. Far too many of the District's exceptional children remain at home, placed on waiting lists and deprived of their best learning years. This practice must cease if children are to develop to their highest potential.

ROBERT L. BOSTOCK.

Subscribed and sworn to before me this 10th day of June, 1971.

———————,
Notary Public.

My commission expires August 31, 197–.

APPENDIX M

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss:

I, BOBBIE McMAHAN, being first duly sworn, depose and say:

1. I reside at 1200 Delaware Avenue, S.W., Apartment 217, Washington, D.C.

2. I am the chairman of the District of Columbia Family Welfare Rights Organization and the mother of four children enrolled in the District of Columbia public schools.

3. On June 29, 1971, I attended a meeting with Dr. John Johnson, Associate Superintendent for Special Education, and parents who have children enrolled in the Area C school program for the emotionally disturbed. At this meeting, Dr. Johnson, in response, to questions concerning tuition grants for children needing special education, stated that he suspected that there is discrimination in the allocation of tuition grants.

4. As the parent of an eight-year-old brain-damaged child, I have tried to get a tuition grant for my son Garret for several months, but all I seem to get is a bureaucratic runaround. At my neighborhood school, Syphax, neither the school counselor nor the classroom teacher told me anything about the existence of a tuition grant program, even though they knew of Garret's classroom difficulties and the head injury he suffered. I was not informed of this special education program until I tried to phone Superintendent Scott. After three days of trying to reach him, I was finally put in touch with an Assistant Superintendent who gave me my first information regarding the existence of the tuition grant program. Only after my protest did this Assistant Superintendent phone Syphax to make sure that Garret would be given a form "205" psychological evaluation and would get some follow-up assistance. Despite these efforts, I have still not heard from the school officials who run the tuition grant program. Mr. Ben Parker of the Special Education Department promised that as of June 1, I would receive a revised form for requesting a tuition grant. About June 5, I called the tuition grant office and spoke with Mrs. Lindo's secretary who told me that none of the parents who requested tuition grants had received this form, which is needed to complete the grant application. This form still has not been sent to me. In addition, the Department of Special Education has never informed me of any of the private schools with whom they contract, who might serve Garret, or offered any assistance to me to get my child accepted by any of these schools. It is difficult to understand how a poor parent is supposed to locate a school that will serve her particular child if the Special Education officials do not offer any information on the different types of resources available. Despite the fact that the time for fall enrollment is fast approaching, no decisions on my application for a tuition grant have been made and no information on available schools services has been provided.

5. Many other poor people in the District are in the same position as I am of waiting for word on whether our children will be served next year. Tuition grants are supposed to be made in the early summer. Places in classes in District schools for children with special education needs are being assigned now. When these places are being handed out, District children who are poor and children who are black are not being served.

BOBBIE McMAHAN.

Subscribed and sworn to before me this 20th day of July, 1971.

WILLIAM J. MARTINS,
Notary Public.

APPENDIX N

AFFIDAVIT

UNITED STATES OF AMERICA
District of Columbia, ss:

The undersigned, Erwin Friedman, being duly sworn, deposes and says:

1. I presently reside at 2226 Richland Street, Silver Spring, Maryland.

2. I hold a Ph.D., *cum laude*, from Pazmany Peter University, Budapest, Hungary (1943–1949). My educational background also includes: Munkacs Gymnasium, Munkacs, Hungary (1940–1943) and post doctoral courses in psychiatry, neurology, and psychology at the University of Vienna, Vienna, Austria (1952–1953).

3. My professional experience includes: 1947–1948, Psychological Consultant, Pduje Svi Residential Center for Problem Children, Budapest, Hungary; 1949–1951, Therapist and Consultant, Bikur Cholim, Vienna, Austria; 1951–1953, Psychological Consultant and Therapist, Misrachi Youth Center, Vienna, Austria; 1955–1957, Supervising Psychiatric Counsellor, Jewish Board of Guardians, Linden Hill Residential Treatment Center, Hawthorne, New York; 1957–1961, Director of Psychological Services, New Jersey State Colony at New Lisbon, New Jersey; 1958–1959, Lecturer in Psychology, Trenton, New Jersey; 1960–1965, Psychological Consultant, New Jersey Reformatory, Bordentown, New Jersey; 1961–1965, Supervisor of Training, Doctoral Program in School Psychology, Rutgers University, New Jersey; 1961–1965, Chief Psychologist and Administrative Associate, Children's Psychiatric Center, Eatontown, New Jersey; 1965 to present, Director, National Children's Center, Inc., Washington, D.C.; 1967 to present, Assistant Professor, Pediatric Psychiatry, The George Washington University School of Medicine, Washington, D.C. A listing of my publications is attached to this affidavit.

4. I am a member of the following professional societies: American Psychological Association (fellow); District of Columbia Psychological Association (member); Maryland Psychological Association (fellow); American Association of Mental Deficiency (fellow); American Orthopsychiatric Association (fellow); American Academy of Psychotherapists (member); New York Academy of Science (member); and American Association for the Advancement of Science (fellow).

5. I am presently the Director of the National Children's Center, 6200 Second Street, N.W., Washington, D.C. The Center provides programs for 140 retarded individuals with all kinds and degrees of handicap. This includes 86 children who are severely or profoundly retarded. Of the 140 individuals in our program, 42 are residential and the remainder participate on a day care basis. We accept adults as well as children. If additional income were forthcoming, I would like to expand my program to accept more retarded children.

6. The Center is a non-profit private institution and our staff includes psychiatrists, pediatricians, psychologists, teachers, nurses, research and training specialists. The Center's range of programs includes: day and residential, respite and emergency, diagnostic, vocational and prevocational training, parents' counselling, referral service, research, and professional and non-professional training.

7. The Center's average day care expenditure per child per year is $2040.00. It is my judgment that while this figure could be beneficially increased to $3,000.00, the three thousand dollar figure would be ample for this or any similar program of day care for the severely retarded or multiply handicapped.

8. The staffing and financial problems in educational services for the retarded are severe; but I believe that our most fundamental obstacles to helping these people realize their potential stem from a misplaced reluctance to recognize the similarity of their needs to other children rather than the differences.

9. I cannot overemphasize the importance of a structured educational program for the severely retarded individual. Such a program in my experience can change the nature of that individual's life in the most fundamental way. We have taken young adults, severe retardates who have spent all their lives in institutions and taught them to become self-sufficient to the degree that they can hold down simple, paying jobs in a sheltered setting, and get to and from work on their own. I have always been disturbed by any concept of "education" that would allow these people to be shut out from the compulsory education laws, so that they are never taught the elementary skills of habit training and social behavior that would permit them to move in the mainstream of life.

Education has to be defined in the broad sense as a process whereby a child learns to live in his environment through the acquisition of knowledge and skills.

Thus, to teach a child to eat, use the toilet, walk on the streets, avoid dangers, and to get along in a social setting with others is a major educational achievement. Toilet training, for example, is a much greater educational "threshold" than the completion of a four year undergraduate program; and the fact that this sort of learning might be labeled "habit training" in no way makes it any less "education" than training an individual to manipulate abstract symbols, which is what reading and writing really is; a skill which, incidentally, half the world functions without.

10. Failure to include in the definition of "education" this basic type of skill-teaching to retarded children has disastrous results for their welfare. For instance, some would advocate "home visits" for the retarded child, on the assumption that primary skills such as oral communication, toilet training, feeding and grooming can be acquired in an informal, unstructured, on-again, off-again learning environment. In my experience this is wrong for a fundamental reason. The severely retarded child, more than normal or less retarded children, needs a formal, structured learning environment. This is because he does not have the inherent capability of other children to learn by watching others or from what goes on around him. This "incidental learning" is the major source of teaching for normal children. The very retarded child on the other hand must be carefully conditioned through repetition and specific instruction in every movement and part of any action that he is expected to learn. As a result he needs more, not less, formal instruction and a longer, not a shorter, school day if he is to advance.

11. The abdication by our educational authorities of responsibility for this vital learning process in the case of our severely retarded children is, in my opinion, a tragic disservice to these children, and to their parents. It means they are denied the benefits of the compulsory education laws and stigmatized as "sick" people who receive "treatment" or "therapy" on a discretionary basis, not the "education," that other children are guaranteed.

ERWIN FRIEDNMAN.

Subscribed and sworn to before me this 28th day of May, 1971.

ANNE PALLIE,
Notary Public.

My Commission Expires Jan. 15, 1976.

APPENDIX—PUBLICATIONS, ERWIN FRIEDMAN

"The Autistic Syndrome and Phenylketonuria." Paper read at the AAMD Annual Meeting, 1965. Miami, Florida;

"A Historical Note to 'The Wild Boy of Kronstadt.'" Journal of Historical Behavioral Sciences, 1, 3, 284, 1965;

"Treatment Programs with Children (Community Programming for the Retarded—Treatment and Rehabilitation)". Paper read at the 90th Annual Meeting of the American Association on Mental Deficiency, May, 1966, Chicago, Illinois;

"Assessment of Basic Motor Abilities in Retardates: Toward a Basis for Skill Training" (with E. H. Elkin). *AIR Monograph*, 96–2, 1967, *JFRC Monograph*, 67–1, 1968;

"The Autistic Syndrome and Phenylketonuria." *Schizophrenia*, 1, 4, 249–261, 1969;

"Children Speak True: Review of *Die Kognitive Orientierung des Kindes*" by H. S. Kreitler. Contemporary Psychology, 15, 3, 1970;

"Missing in the Life of the Retarded Individual: Sex." *Journal of Special Education*. Will be published in the summer of 1971;

Me Balati (book on psychology of symbols), Budapest, Hungary;

Das Himmlische Jerusalem, Eine Symbolpsychologische Deutung, A. Joodse Wetenschap 9, 130–3, 1956;

"A Method to Record and Evaluate Activity Involvement of Childhood Schizophrenia in a Residential Treatment Center," APA Journal, 1957;

"Mental Disorder and Mental Deficiency." Welfare Reporter, 9, 124–132, 1958;

"Spruce: A Plan and Research Design for a Residential Treatment Center for the Emotionally Disturbed Retardates." (Submitted to the Department of Institutions and Agencies, for the State of New Jersey), Trenton, 1958;

"Defective Delinquents Reconsidered." Paper read at the AAMD Annual Meeting, 1960;

"Analysis of Test Patterns of Mentally Defectives with and without Affective Deprivation in Childhood." *Acta Psychologica*, 19, 407–408, 1961;

"Individual Therapy with a 'Defective Delinquent,'" *Journal of Clinical Psychology*, 17, 229–232, 1961;

"Comparative Studies of Szondi Profiles of Institutionalized Mentally Defectives." *Beiheft zur Schweizerischen Zietschrift fur Psychologie*, 43, 137–141, 1962;

Essay on V. E. Frankl's book *From Death Camp to Existentialism*. Journal of Religion and Mental Health, 1, 408–410, 1962;

"Are We seeing the Right Patients?" Symposium, American Orthopsychiatric Association, Chicago, Illinois, 1964;

"Phenylketonuria in a Negro-Indian." Paper read at the AAMD Annual Meeting, 1965, Miami, Florida;

APPENDIX O

AFFIDAVIT

UNITED STATES OF AMERICA
District of Columbia, SS:

The undersigned, Joan C. Gendreau, being duly sworn, deposes and says:

1. I presently reside at 604 South Spring Street, Falls Church, Virginia.

2. I am the director of the Cooperative School for Handicapped Children, located at 541 Marshall Road, S.W., in Vienna, Virginia. I have previously been employed as a teacher of handicapped and normal children for five years as well as administrator at the secondary school and university level. I have a Master of Arts degree in educational psychology from the University of Minnesota as well as many additional graduate courses related to the education of handicapped children.

3. The Cooperative School for Handicapped Children accepts mentally retarded children, age three to twenty-one, whose needs are not met by the public school facilities in the area. There are no restrictions of any kind on accompanying handicaps, except that the child's behavior must not endanger others. There are no self-care requirements and children need not be toilet-trained, self-feeding, nor ambulatory. Most of the children enrolled this year have multiple handicaps.

4. The cost of our program this year has been $1625 for tuition and $500 for transportation per child.

5. Currently eight children are enrolled in the Cooperative School through the District of Columbia tuition grant program. Three of these children might be classified as trainable and the other five "non-trainable" according to prevalent custom in special education. All have one major accompanying handicap—visual, orthopedic, behavioral, etc., and most lack self-care skills. One child, now eleven years old, has never been enrolled in school before this year.

6. Even the most retarded, the most handicapped child in this group from the District of Columbia, has profited from his training at the Cooperative School. Though most of these children would be placed in the custodial or non-trainable category, we view them as capable of growing, developing and learning. Although progress may be very slow, each child has indeed learned something this year—to chew and swallow, to walk with assistance, to use his hands to feed himself or hold a crayon, to focus attention on a learning task, and so forth. This may not be regarded as education in the academic sense but these children do learn vital new skills and broaden their understanding of the environment with patient, persistent, individualized teaching. Although the rate of learning is slow, the satisfactions for both pupil and teacher are tremendous.

7. We currently have an enrollment of 72 pupils. Our eligibility requirements and admissions procedures are purposely very minimal, because for our clients we are, in most cases, the only alternative to keeping the child cloistered at home or institutionalizing him away from the community. Our pupils have been refused admission to or put out of public school facilities because of the severity or multiplicity of their handicaps. What is needed, therefore, is a school that will eagerly admit these children and help them learn in spite of their handicaps.

8. Of the 61 school-age children (6 through 20 years of age) all of those from Virginia have received tuition grants or tuition reimbursement this year. In all except 5 instances, funds from local and state sources covered the entire cost of tuition.

9. The staff of the Cooperative School for Handicapped Children is currently composed of a director, administrative assistant, twelve classroom teachers, two speech therapists, one physical therapist, one music teacher, one physical education teacher, eight teachers' aides, three matrons, a handicapped helper and custodian.

10. What seems to be most needed in the area of special education tgday is a new way to think about our retarded children—their needs and how to meet them. Basic to this is the necessity of changing the system of categorizing the retarded into educable, trainable and custodial groups for educational purposes. Obviously, if one views a person as "non-trainable" or custodial, little need be or will be done to help him develop even the limited or hidden potential he has. On the other hand, if this third group is viewed as "teachable", then one is obligated to help him learn. Beyond a new philosophy, what is required is a school or center where such "teachable" children can be brought together in small groups (Co-op School classes average 6 pupils to one teacher with one teacher's aide) and a staff trained to meet the special needs of these children and dedicated to a belief in the dignity of every human being without regard to the severity of his handicap or the limit perimeters of his potential.

JOAN C. GENDREAU.

Subscribed and sworn to before me this 1st day of June, 1971.

ANNE PALLIE,
Notary Public.

My Commission Expires January 15, 1976.

APPENDIX P

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia, ss:

The undersigned, William P. Argy, being duly sworn, deposes and says:

1. I presently reside at 5201 Connecticut Avenue, N.W., Washington, D.C.

2. I am the Medical Director of the District of Columbia Society for Crippled Children. I have held this position since 1950.

3. My professional background includes the following: I obtained an M.D. degree from Georgetown University in 1922; from 1931 to 1954 I served as Chief of Medicine at Providence Hospital, Washington, D.C.; I am currently a consultant in medicine for that hospital; and I am also Professor of Medicine, emeritus, of Georgetown University.

4. As Medical Director for the D.C. Society for Crippled Children, I have long been interested in the educational, as well as health needs of the so-called "exceptional child."

5. The school run by the D.C. Crippled Children's Society was set-up as a demonstration project in 1944 when it became evident to certain concerned individuals that no school in the District could or would take pre-school children who had cerebral palsy. Since that time the size and character of the program has changed considerably.

6. Our staff is presently composed of six teachers, six therapists (physical, occupational and speech), four teacher's aides, and a psychologist. In addition the program has an over-all co-ordinator. Volunteer workers from the Red Cross, Junior League, and Junior Auxiliary, as well as unaffiliated individuals, aid in our program.

7. Presently our program serves, on a day care basis, some 103 pre-school age children of varying types of handicap.

Of these students, approximately 16 are in the below 30 I.Q. category. While the uninformed might say these children are not trainable and, therefore, not in need of educational opportunity, it has been our experience that this is an incorrect and damaging view. Our experience indicates to the contrary that these children, perhaps even more than "normal" children, can—and do, when given the opportunity—benefit from education made specific to their needs.

Initially these children are in need of the self-help skills: toilet, feeding, walking, basic language skills, and awareness of self and others in the environment. Our program is designed to teach such fundamental skills.

8. Our program is funded in part by the sale of Easter Seals, the bulk of expenses being made up from voluntary contributions. We charge no tuition, except that some of our parents are charged tuition if they are eligible to have that money actually paid by a third party such as Medicaid or the D.C. Tuition Grant program. Our cost per child for the annual half-day program is $1800. Parents are required to furnish daily transportation.

9. Present limitations on space and funds have dictated that our program be limited to pre-schoolers. Yet we are concerned because those who must leave our program at school age have no place to go to continue their education. Thus, we

have projected—when funds become available—the building of three new classrooms so that we can expand our program to include students from the 7-12 age group.

William P. Argy.

Subscribed and sworn to before me this 8th day of August, 1971, in the District of Columbia.

——— ———,
Notary Public, D.C.

My Commission expires ——— ———.

Appendix Q

AFFIDAVIT

United States of America,
District of Columbia, ss:

The undersigned, Kathryn A. Gorham, being duly sworn, deposes and says:

1. I presently reside at 6216 Wiscasset Road, Bethesda, Maryland.

2. I was a resident of the District of Columbia for ten years, from 1960 to 1970. In September of 1970, my husband, five children and I moved to Maryland.

3. In 1961 my fifth daughter was born profoundly retarded.

4. In 1967 she began school at the Cooperative School for Handicapped Children in Arlington, Virginia. When the school moved to Vienna the same year, I drove eighty miles each day, taking her to school in the morning, returning home so that I would be home to give my other children lunch when they came home from the neighborhood public school, and returning to Vienna again to pick her up. I did this because there was no school which would accept her in the District of Columbia—neither public nor private.

5. My interest in programs for the severely and profoundly retarded, physically handicapped children in the Metropolitan area grew during the next years, along with my concern for District parents whose children were not receiving the benefit of any program whatsoever.

6. In 1967 and 1968, on a volunteer basis, I visited programs for retarded children throughout the Metropolitan area, gathering basic information for a directory of services for the handicapped which would be a helpful guide for parents in their search for the services their children needed. With the support of various agencies it was published in 1968.

7. On May 1, 1968, I appeared at an Open Hearing before the D.C. Board of Education asking that a pilot program for profoundly retarded children be included in the FY '69 budget under consideration. The Board was receptive and included a pilot project for twelve children at the cost of close to $3,000 per year per child. The project was eliminated in one of the final steps of the budgetary process, just before approval by Congress.

8. The following year, I was told by Dr. Jackson that there were teachers and aides available for a small program for severely retarded, non-ambulatory children if space could be found. I located suitable rooms in a church (People's Congregational), but no funds were available to pay the rent the church required.

9. In December of 1969 and January of 1970, with the same assurance that teachers and aides, as well as some equipment, could be provided by the schools, I worked with Dr. Enid Wolf of the D.C. Developmental Center for Special Education on a proposal to the Hospital for Sick Children for a cooperative training program to be located in the Hospital's empty wing. This too failed—again, it appeared, because the schools were unable to contribute any funds towards the arrangement.

10. In September of 1969 I had become the first director of the Information Center for Handicapped Children, a non-proqt, federally funded project whose purpose is to collect information on services in the Metropolitan area for children with mental, emotional or physical handicaps and to give personal assistance to parents in finding the services their children need.

11. From the time of the opening of our Center in February of 1970, every couple of weeks brought in at least one call from the parent of a severely mentally and physically handicapped child in need of assistance of one sort or another—or from agency workers trying to find help for such children.

12. In spring of 1970 we arranged with the Cooperative School for Handicapped Children to send one of its seven mini-buses to a pick-up point in the District for D.C. children, helped the parents to apply to the school and helped them apply

for tuition aid from the Board of Education. Nine D.C. children are bussed 20 miles to the school during this school year (1970–71). Eight are funded ($1420) by the Board of Education, though the full cost of transportation ($500) is not covered by the Board's allotment ($250).

13. The number of such children in need of training programs has continued to mount until, at this time, 57 school-aged children are known to our Center. There may be as many as twice that number unknown to us.

14. Twenty-eight of the severely and profoundly retarded children known to us have applied for placement to the District institution for the retarded, Forest Haven in Laurel. The building for severely or profoundly retarded, non-ambulatory persons is called the Infirmary. It is what is known as a non-elastic facility. It is full, and vacancies are so rare that one family has waited for ten years for admission for their totally helpless son, eight have waited six years and most of the rest have waited at least three years.

15. Although parents in my position are persistently advised to institutionalize their children by physicians, school personnel, well-meaning friends and relatives, obviously the advice stems from ignorance. But even if placement in the D.C. institution were a real possibility, I believe that many of these families would prefer not to institutionalize their children if they were given the support and help of a 9 to 3 school training class for their children.

16. With respect to potential facilities in the D.C. public school system for the necessary programs, the Sharpe Health School and the new Mamie D. Lee School to open in September are free of architectural barriers and could house special classes for the severely and profoundly retarded. With such facilities, a training program should provide for a teacher and an aide for every six to eight children. Ideally, physical therapy should be available to them. Staff should receive preservice training in the special methods of reaching these children. Models of such special methods can be observed at the Vienna Cooperative School and other programs in the area.

17. Because most of the children in question have never had training of any kind, a few may need to be prepared for entry into a training program. There is expertise available—either from behaviour modification specialists in the D.C. School's Developmental Center for Special Education or from Dr. Leo Walder, who is presently developing a project to train parents to help their children develop the skills and behavior which will bring them to the point of acceptability for special education classes. Whatever the cost of such extra input, it would seem to me that the expenditure is only just and humane as an attempt at compensation for years of doing without any assistance.

Kathryn A. Gorham.

Subscribed and sworn to before me this — day of May, 1971.

Anne Pallie,
Notary Public.

My Commission Expires Jan. 15, 1976.

Appendix R

AFFIDAVIT

United States of America,
District of Columbia, SS:

I, KATHRYN CAMPBELL, being first duly sworn, depose and say:

1. I reside at 2131 Florida Avenue, N.W., Washington, D.C.

2. I am an Assistant Editor of *Chemical and Engineering News*, a publication of the American Chemical Society. I am a volunteer member of For Love of Children, Inc. (FLOC); specifically, I am a member of the Rehabilitation Mission Group of FLOC, secretary of the organization, and editor of the FLOC Newsletter.

3. As part of my FLOC volunteer work, I began in December of 1969 to try to find a school for Susie Carter, then seven years old and without any educational program. During the 1968–1969 school year, Susie attended the Kendall School for the Deaf, but this private facility would not take Susie back because the school was not equipped to handle her dual handicaps. Despite repeated efforts by Susie's mother and myself, Susie remained without any program of education from June of 1969 through September of 1970.

4. Susie Carter is a partially deaf and slightly retarded child, eight years old, black, and an AFDC recipient resident with her mother, Mrs. Anna Wade, at

320 Kentucky Avenue, S.E., Washington, D.C. She has never attended public school in the District of Columbia because of her physical handicaps. As a result of Susie's lack of schooling, her mother had to stay at home and could not be employed.

5. From December of 1967, members of our organization made it their special concern to get Susie placed in a school. As a result of the efforts of Mrs. Keister, Susie did go to the Kendall School for the Deaf but as of June 1969, she was once again without schooling of any kind.

6. I began my efforts in December, 1969, and secured lists of telephone numbers and contacts from Mr. Tom Bull, a teacher at the Kendall School, and Mrs. Dorothy Miller, a caseworker at Children's Hospital. I began calling about February 17, 1970. Between then and July 9, I made about sixty-three phone calls to various officials and placement resources, including Mrs. Gaylord, a school health worker, and Mrs. Mamie Lindo of the Department of Special Education of the School Board. At Mrs. Lindo's office, either the line was busy or some assistant would answer the phone to say that Mrs. Lindo would call me back because she was in a meeting, on another line, in the field, and so on. One of my last calls to the Office of Special Education connected me to a recording which related the following: "The Office of Special Education is on vacation. Call again July 20."

7. On April 28, 1970, I wrote a letter with other members of the FLOC group to Mr. William Rich, chairman of the Board of Education's Advisory Committee on Special Education, advising him of Susie's need and asking if he could lead the way to providing some sort of program for trainable deaf and retarded children. There was no reply. I followed up with another letter on July 9. On July 17, 1970, I received a letter from Mr. Rich, who included some literature on procedures of which we were already aware an expressed the hope that we would eventually succeed in helping Susie. His letter did not sound as though he had even read ours of April 28, let alone realize that we were asking him, in his official capacity, to do something right away.

8. We would still be futilely calling various agencies and school officials had we not luckily talked to Mrs. Thelma Rutherford, Director of Information and Referral Service of the National Capital Area Health and Welfare Council. Mrs. Rutherford is a personal friend of Miss Clara Reagh of the Washington Hearing Society, and she made a special project of recommending Susie for placement in the Society's school at 1934 Calvert Street, N.W., Washington, D.C., which accepted Susie without funding and even though she was over the admission age.

9. Susie has been attending the Washington Hearing Society's school on Calvert Street, a private facility, since September, 1970. She cannot return after the end of the present term sometime this month, as she was already over-age at the time of her admission. Thus she will once again be without any school placement of any kind.

10. Members of FLOC have continued to tutor Susie, and the principal of the Calvert Street school has taken a special interest in Susie and has observed many things that were not obvious in the quick tests she had previously received in public clinics. The principal believes that the place for Susie is the St. John's Child Development Center on MacArthur Boulevard, and has encouraged Susie's FLOC sponsors to apply there for her admission in September of 1971, and this application has been made.

11. Since St. John's, too, is a private facility, Susie will need a tuition grant from the Board of Education if she is to attend. As of this date, no such grant has been approved. When Susie's mother, Mrs. Wade, contacted the Department of Special Education to apply for a tuition grant, she was told by letter to come to the Special Education office during the week of June 7, 1971. As of this date, therefore, it is uncertain whether or not Susie will be attending school in September.

12. If determined, well-heeled, and articulate people can hammer away at this problem for about two years without really getting anywhere, what do people who lack these assets do to secure an education for their handicapped children?

KATHRYN CAMPBELL.

Subscribed and sworn to before me this 8th day of June 1971.

JAMES COHEY, JR.,
Notary Public.

My commission expires 6/14/75.

APPENDIX S

AFFIDAVIT

UNITED STATES OF AMERICA,
District of Columbia ss:

I, ROBERT L. BOSTICK, being first duly sworn, depose and say:

1. I reside at 1428 Whittier Street, N.W., Washington, D.C.

2. I am employed by the Library of Congress as a visual information specialist.

3. For the past eighteen years, I have been actively engaged in activities to enhance the educational opportunities for the handicapped children of the District of Columbia within the public school system. My wife and I are parents of a midly retarded daughter, Barbara Ann Bostick, now twenty-three years old. I have been a member of Help for Retarded Children, Inc., which is the D.C. chapter of the National Association for Retarded Children, for the past seventeen or eighteen years, and a member of its Board of Directors since 1956. I am also a charter member of Concerned Citizens for Exceptional Children, an "umbrella" group consisting of several organizations representing the interests of children of all handicapping conditions. I am a member of the D.C. Public School's Task Force on Special Education. I recently joined D.C. Federation No. 524 of the Council for Exceptional Children.

4. I wish to emphasize the need for prompt action in declaring the right to a public school education for *all* compulsory school age children, if previously excluded children are to be able to attend school in September, since (a) time for parental planning for all enrollment is needed, and (b) school commitments for teachers, space, and other resources must be made.

5. At this time, tuition grants for the 1971–72 school year are still to be distributed. In the past there have been cases of discrimination in favor of articulate, aggressive middle class parents, while children of the poor all too frequently have been denied aid.

6. A new public school for some District mentally retarded youngsters is scheduled for opening within the next few weeks. Its maximum capacity is 200, but initially only 160 children will be enrolled. The assignment of children to attend this school will be made within the next few weeks. Even with this addition, hundreds of mentally retarded children will still be unserved by the public schools. Many of these children, especially those languishing at home, are losing their best learning years.

7. Absence of classes for educable mentally retarded children has resulted in some youngsters being "excused" from school attendance because of their behavior; excluded because in fact no provisions for their needs have been made. The lack of programs for the educable mentally retarded in the D.C. public schools is unique for a city this size, due to the school system's misconstruction of the Wright decree in *Hobson* v. *Hansen* that abolition of the tracking system makes any such services impermissible. To clarify paragraph 9 of my Affidavit of June 9, 1971, I do not wish to imply that separate homerooms must be provided for all handicapped children, but rather, that public schools must provide adequate resources, including separate homerooms for those exceptional children who cannot make it in the regular classroom even with the MIND program.

8. The regular school budget is the major source of funding for programs of special education. The budget submitted by the Board of Education for the 1971–72 school year before Congress does not, however, request sufficient funds for those publicly supported education programs intended to serve children on waiting lists. Even though Senator Daniel Inouye, Chairman of the D.C. Subcommittee to the Senate Appropriations Committee, has expressed his support for increased appropriations this year to eliminate the waiting lists, the budget for special education submitted by the Board of Education remains substantially unchanged. This failure to request adequate funds, under the Board's present plan for allocating resources, will leave hundreds of D.C. youngsters without a publicly supported education.

ROBERT L. BOSTICK.

Subscribed and sworn to before me this 20th day of July 1971.

ANNETTE B. YOURTY,
Notary Public.

My commission expires August 31, 1971.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No.—

PETER MILLS, ET AL., PLAINTIFFS *v.* BOARD OF EDUCATION OF THE DISTRICT OF COLUMBIA, DEFENDANTS

VERIFICATION

I, EASTER BLACKSHEARE, being first duly sworn, on oath say that I am one of the plaintiffs in the above cause and affirm that I have read the complaint and believe the allegations stated therein to be true. I further swear and affirm that I believe that my son, Duane, will suffer immediate and irreparable harm if Defendants continue to fail to provide him with a publicly supported education.

EASTER BLACKSHEARE.

Subscribed and sworn to before me this 21st day of September, 1971, in the District of Columbia.

R. M. WALLER,
Notary Public.

My commission expires July 14, 1976.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No.—

PETER MILLS, ET AL., PLAINTIFFS *v.* BOARD OF EDUCATION, ET AL., DEFENDANTS

MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Rule 65, Federal Rules of Civil Procedure, and on the basis of the verified Complaint and Affidavits filed herewith by Duane Blacksheare and others, plaintiffs, by their attorneys, hereby move that Defendants be preliminarily enjoined from:

1. Continuing to exclude the named plaintiff children from publicly-supported education and from failing immediately to provide such children with appropriate publicly-supported educational services;

2. Within fourteen days of the entry of the Preliminary Injunction Order of this Court, failing to submit to this Court and counsel for plaintiffs a list showing the name, address, and telephone number of each child presently suspended, expelled, or otherwise excluded from publicly-supported education and stating the date and length of each such suspension, expulsion, or exclusion and the reason therefor;

3. Within forty-eight hours of the submission of such list, failing to notify the parents or guardian of each such child of that child's right to a publicly-supported education now and hereafter and of that child's proposed educational placement in an appropriate class in the 1971 Fall school term.

The grounds for this motion are:

1. Continued exclusion of the plaintiffs from publicly-supported education will continue the denial to plaintiff children of their constitutionally protected right of access to an equal educational opportunity.

2. Defendants have failed to fulfill their prior express commitment to provide plaintiffs with a publicly-supported education in the 1971 school year, which began on September 10, 1971. Defendants' continued failure to fulfill this commitment has caused plaintiffs further delay in receiving their right to an opportunity for education.

3. Defendants' failure to enroll plaintiffs in classes in the past and at the outset of the Fall term has unjustifiably handicapped their prospects for academic progress and a satisfactory classroom adjustment. Continued denial of educational opportunity will heighten such handicap and will cause plaintiff children to suffer

further immediate and irreparable harm and depreciation of the benefits inherent in their constitutionally and statutorily protected right to a publicly-supported education.

Respectfully submitted.

JULIAN TEPPER,
NLADA National Law Office,
Washington, D.C.
STANLEY HERR,
NLADA National Law Office,
Washington, D.C.
PATRICIA WALD,
Center for Law and Social Policy,
Washington, D.C.
PAUL DIMOND,
Center for Law and Education,
Harvard University,
Cambridge, Massachusetts.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

C.A. No. —

PETER MILLS, ET AL., PLAINTIFFS *v.* BOARD OF EDUCATION OF THE DISTRICT OF COLUMBIA, ET AL., DEFENDANTS

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF THE MOTION FOR PRELIMINARY INJUNCTION

1. Rule 65, Federal Rules of Civil Procedure.
2. *Hobson* v. *Hansen*, 269 F. Supp. 401 (D.D.C., 1967), Memorandum and Order of May 25, 1971, and Ruling on the Motion to Intervene, (July 23, 1971, at 3–5).
3. The nature of the controversy between plaintiffs and the Defendants is set forth in the Verified Complaint and in Affidavits thereto.
4. The nature of the irreparable injury is set forth therein, as well as in the Memorandum in Support of the Verified Complaint.

Respectfully submitted.

JULIAN TEPPER,
NLADA National Law Office,
Washington, D.C.
STANLEY HERR,
NLADA National Law Office,
Washington, D.C.

"Report of the Superintendent's Task Force on Special Education"—Public Schools of the District of Columbia—December 1971

Report of the Superintendent's Task Force on Special Education

PUBLIC SCHOOLS OF THE DISTRICT OF COLUMBIA, DECEMBER 1971

The Task Force

On March 5, 1971, the Task Force on Special Education was officially constituted by the Superintendent of the District of Columbia Public Schools, Dr. Hugh J. Scott. The mandate given the Task Force at that time empowered them to take a critical look at the special education program of the District of Columbia Public School System and to offer recommendations leading to solutions in the form of an initial report due on or before June 25, 1971.

The Task Force was comprised of members from the community at large: parents, private and public agencies, teachers, school administrators, the Board of Education, and interested citizens. The methods utilized for the collection, analysis, and conclusions drawn were based upon information gathered through open and closed hearings; committee sessions with relevant school administrators; visits to public and private schools and institutions; questionnaires; interviews; communication with authorities on special education; and review of related literature.

The intent of the Task Force was to permit wide dissemination of this report to the public shortly after delivery to the Superintendent of Schools. Additionally, the Task Force desired that the Superintendent elicit the involvement and suggestions of the District of Columbia Public Schools professional personnel and the community in the discussion and implementation of the recommendations emanating from this Task Force.

The report contains short- and long-range goals which the school system must meet in addressing itself to the critical problems facing handicapped children in the District schools. We thank all concerned individuals who contributed information and made this report possible.

MEMBERS OF TASK FORCE ON SPECIAL EDUCATION

Mrs. Muriel Alexander
Mrs. Rose Alpher
Mrs. Louise Appell
Mrs. Rena Becker
Mr. Robert Bostick
Dr. Perry Botwin
Mr. Alfonso Brown
Mrs. Rose Bulow
Dr. James Byrd
Dr. Bertice Cornish
Mrs. Ethel Dalmat
Mrs. Sandra Fromm
Mrs. Yetta Galiber
Mrs. Kathryn Gorham
Mrs. Veta Harrison
Mrs. Azalee Harrison
Dr. Ruth Hayes
Mrs. Dorothy Howard
Mr. Maceo Hutcherson
Mrs. Rosalie Iadarola
Mr. Burnell Irby,
  Task Force Chairman
Dr. John Johnson,
  Task Force Consultant
Mrs. Dorothy Kennison
Mrs. Mary King
Mrs. Inez Lattimore
Mrs. Orelia Ledbetter
Dr. Nicholas Long
Mr. James McCord
Rev. Chester McDonald
Dr. Jacqueline McMorris
Dr. James Moss
Mrs. Patricia Nagle
Rev. Archie Oliver, Jr.
Mrs. Mitzi Parks
Mrs. Ruth Pearl
Mr. Ben Rathbun
Mr. William Rich
Mrs. Grace Robinson
Dr. Pearl Rosser
Mrs. Barbara Lett Simmons
Mrs. Sally Smith
Mrs. Josephine Teague
Mrs. Maureen Thomas
Mr. Robert Wehrli
Mr. Peter Williams
Dr. James Wise
Dr. Ralph Wittenberg
Dr. Doris Woodson,
  Task Force Staff Director

I. INTRODUCTION

Forword

The right of a child born in the United States to receive a public school education regardless of his race, creed, color, or sex has been affirmed again and again, philosophically and legally. Yet within our borders for thousands of children this right is more a matter of lipservice to a noble ideal than an actuality. Whatever the rationalizations used to explain this denial of opportunity to some of them, the fundamental concept of their right to public education is seldom at issue. No so for the handicapped child. Buried beneath the accumulation of shame, fear, ignorance, rejection, neglect and almost stifled by the dreadful weight of charity, is this child's right to be educated at public expense. The historically slow and painful process of federal and state legislation-by-disability, with all of its implications of continuing exclusion for those whose impairments received no legislative dispensation, bears witness to the presence of our failure to accord this child his right to be educated and to assume the responsibility that it entails.

In the city of Washington, the acknowledgement of the right of the handicapped child to public education has been honored more in the breech than by observance. The obscene nightmare of repetition from year to year continues for the parents of these children who must compete for placement and funds or accept the exclusion of their child from the opportunity to develop his human potential.

Therefore, the Task Force on Special Education demands that the Board of Education, the City Council, and the Congress of the United States act cooperatively to end this cruel and unusual punishment of parents, and this denial of the right of the handicapped child to public education in the District of Columbia.

We ask that new and revised laws and the appropriation of funds be provided to assure that Special Education shall exist in this city. Further, we ask that these programs and services be continuous so as to assure the fullest possible physical, intellectual, and social development of children whose needs require resources and assistance presently not available in the regular school setting.

We propose that the Board of Education announce publicly the responsibility of the public school system of the District of Columbia to provide education and training for all District children regardless of the kind or degree of individual disability.

Taxonomy

We define Special Education as that part of general education which devotes its attention to students who are considered to exhibit impairments, disabilities, or handicaps in any form or combinations, with the assumption that such conditions contribute to the students' inability to develop to their maximum capacities in the regular educational program:

Impairment.—Defective bodily structure (senses, systems, organs, members, etc.).

Disability.—A limitation of activity when compared with other individuals of similar age, sex, and culture.

Handicap.—A reduction of personal or social efficiency and the stigma therefrom.

These pupils (children and youth) are generally known as "exceptional" in terms of the usual manner of classifying human problems. A Department of Special Education exists for the purpose of educating those who are exceptional physically, mentally, or emotionally to the extent that they require special educational services.

Philosophy

The D.C. Public Schools, in order to demonstrate its commitment to each individual student, should actively seek to:

- Maintain equality of educational opportunity for *all* students.
- Develop a varied curriculum with a comprehensive program of studies for *all* students.
- Provide a quality educational program at a reasonable cost.

To re-emphasize, Special Education shall exist to provide, *by law*, continuous educational services and programs essential to the full intellectual and social development of children who require resources and assistance beyond that available within the regular classes.

Students must be studied as individuals and as interacting members of a social group. Learning in school is an individual process; however, the student's interaction with his physical and social environment significantly influences what he learns and how well he learns it. Teachers and other personnel must therefore interpret each child in terms of the social environment that nurtures him and determine to a considerable extent how he grows.

Every effort must be made to provide, through a wide range of flexible programs and services, for maximum involvement of all children consistent with the above philosophy and with optimum service to each child. Compatible with the above philosophy, the Task Force on Special Education was established.

Rationale

In a memorandum, February 10, 1971, the Superintendent of the Public Schools of the District of Columbia, Dr. Hugh J. Scott, gave a rationale for the formation of a task force on special education in which he stated that, "*It is apparent our present design does not meet the needs of all youth requiring special educational services.*" Subsequently, in the process of carrying out its objectives as defined by the eight-point charge developed from that memorandum, the Task Force on Special Education was to have the truth of that statement brought home by the testimony of community leaders, parents, and school administrators; by persons engaged in providing special educational services; and by examination of existing structures and resources for special education in the District of Columbia Public Schools. As a follow-up measure emphasizing the desperate concern and need for a broader program, the Superintendent has announced that Special Education will be given *Number Two* priority this school year, 1971–72.

However, the Task Force has found reason for cautious optimism in the obvious concern of parents and professionals, members of the Board of Education, the City Council, the Congress, and the federal government. Also, recent months have brought some promising developments within the public schools themselves: the employment of an Associate Superintendent for Special Educational Programming; a proposed restructuring of the Department of Special Education; and a higher priority given this aspect of education in the Superintendent's "Design for Academic Achievement," with its commitment to making the education of all children in the District of Columbia "special."

The Task Force analyzed many prior studies and noted numerous recommendations for the improvement of educational opportunities for the children of Washington, D.C. Many of these recommendations were not implemented due to conflicting interests and to bureaucratic processes of the D.C. Public School System. Thus, the Task Force has directed its attention into the development of two kinds of recommendations: (1) short-term, immediate action-oriented proposals whose implementation requires only acceptance and follow-through by school administrators and personnel; and (2) long-range proposals that require community involvement and Congressional Action.

Objectives

The Task Force on Special Education has been charged to:

- Study existing reports and proposals relative to special education programs in the D.C. Public Schools.
- Pull together available knowledge in urban education and expertise in the development of special education programs for D.C. youth.
- Evaluate existing programs in the D.C. schools.
- Examine the structural and social functions of the Department of Special Education.
- Assess the needs of the Department of Special Education in terms of the number and categories of children to be served, physical facilities, and personnel.
- Develop short- and long-range plans taking into consideration projected handicapped populations.
- Develop plans for the use of current and potential community resources including area universities.
- Recommend to the Board of Education a comprehensive proposal of the action necessary to effectively educate all children with learning disabilities in the D.C. Public Schools.

In order to accomplish these objectives, the following committees were established:

—Structure and Administration;
—Staff: Administrative, Teaching, Para-Professional, Non-Teaching;
—Instruction and Pupil Placement;
—Special Services;
—Staff Development;
—Special Education and the Community;
—Primary and Secondary Intervention.

The Task Force on Special Education consisted of approximately 25 knowledgeable persons—professionals, parents, and others—drawn from concerned citizen groups, universities, government agencies, and the D.C. Public Schools.

II. ADMINISTRATION AND STRUCTURE

Conclusions

The administration of special educational programs in the D.C. Public Schools has been characterized by fragmentation of responsibilities and authority. It has been hampered by a lack of dynamic leadership responsive to the needs of exceptional children and their families. These facts plus many more have been uncovered in the Passow study that stresses the need for specific urgent changes.[1]

Inasmuch as the emphasis is now changing from self-contained classrooms to integration into the mainstream of public education, strong, resourceful and innovative managerial skills are of the utmost importance. Persons charged with the task of administering a viable special educational program must be thoroughly competent within the discipline, and also capable of assessing and demanding all the resources required to meet the individual needs of the child.

A flexible and comprehensive program must be formulated to meet the varied needs of handicapped children: diagnosis in early childhood and continued re-evaluation, special sequential curriculum planning, family counseling, habilitation and rehabilitation, health services, recreation and vocational training.

The Board of Education has never formulated plans for the education of all the schoolaged handicapped children of the District of Columbia. This has been reflected in the perennial low priority given Special Education in its budget requests. The results of the tuition grant program have been costly and the number of students served and the types of services rendered have been limited. Whereas the number of applicants far exceeds the number of grants given, thereby creating a long waiting list, evidence indicates that the most severe cases of the handicapped have not been the ones granted funds in numerous instances. Further, private institutions serving recipients of tuition grants have not been inspected regularly for adherence to acceptable operating standards and to non-discriminatory provisions for student enrollment and professional staff.

The Task Force recognizes the inadequate physical plants and facilities in our public school system for handicapped children. It is obvious that school planners must reorient their thinking if the exceptional child is to be assured his share of the total classroom space and equal educational opportunities.

It is recommended that.—

- Special education programs and any related diagnosis, evaluation and placement procedures be under the Associate Superintendent of Special Educational Planning and that there be appropriate transfer of diagnosis and placement activity and necessary staff from the Department of Pupil Personnel Services.[2]
- All administrative staff positions of the Department of Special Education be reviewed in terms of:
    - —Qualifications and effectiveness of the person filling the position.
    - —Responsibilities assigned to the position.
- An administrator directly responsible to the Associate Superintendent of Special Educational Programming be designated to investigate funds available from Federal, municipal, and private sources to finance programs for the handicapped.
- A professional advisory board be provided for each disability area within the Department of Special Education. The Board would advise on policies, curriculum, and quality of services offered.
- Paid consultants be available to the Department of Special Education to assist where required in the technical aspects of special educational programming and for medical, psychological, sociological, and psychiatric areas.
- An intensified career development program be established within the Department of Special Education, and that the Department share in the responsibility for finding gainful outside employment for handicapped youths and young adults, as well as within the school system itself.
- A qualitative long-range program be developed immediately to meet the needs of the educable mentally retarded (EMR) and the trainable mentally retarded (TMR) in the D.C. Public Schools, including job training in the community.
- No child be excused from attending public schools because of handicapping conditions.

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[1] **Passow Report, 1965–66.**

[2] **Letter, Chairman, Task Force on Special Education to Dr. Hugh J. Scott, June 1, 1971, strongly urging this recommendation for inclusion in reorganization plans.**

- The tuition grant program be carefully reviewed with emphasis on:
  - —The appointment of a qualified person whose sole responsibility is the tuition grant program.
  - —An open registry.
  - —Continuous on-site evaluation of all facilities receiving children on grants.
  - —An individual assessment of each child currently on a grant by a source other then the institution receiving the grant.
  - —Limitation of grant awards with priority given to those whose needs needs cannot be met in D.C. Public Schools.
  - —A review of the present system of record keeping and revision of processing methods.
  - —A complete re-evaluation of all children presently enrolled in TMR classes.
  - —The Department of Special Education assuming the responsibility for finding private facilities for handicapped children.
  - —A liaison being established with the Social Services Administration with an eye toward separating education and living portions of the tuition, and sharing the cost between the two departments.
  - —The current tuition grant program being phased out as soon as it becomes operationally feasible to supplant such programs with adequate services within the D.C. Public Schools. To meet these objectives, enough funds should be sought in the Fiscal Year 1972 budget (or supplementary appropriations), by either seeking an increase in tuition grant funds or the establishing of required classes.
- The Superintendent issue instructions to buildings and grounds for the immediate revision of all plans for schools either proposed or presently under construction for the purpose of including physical provisions (ramps, rails, elevators, etc.) to allow for the integration of handicapped children into the regular educational mainstream.
- A complete survey of existing school facilities be made to determine what physical changes are feasible to provide for the handicapped.
- The original budget set up by the Department of Special Education based on the actual needs for educating all exceptional children be submitted to the Congress. Any modifications which have been prepared by the school and/or city budget offices should be submitted under separate cover.
- Budget requests report the previous year's allocation in terms of the amount of the request by program and the actual amount spent.
- All program facilities, services, and personnel earmarked under Special Education must be placed under the administrative and fiscal control of the Associate Superintendent for Special Educational Programming.

III. STAFF

Conclusions

It has been found that the present certification requirement of six semester hours for Special Education teachers in the District of Columbia is totally inadequate and is not compatible with existing licenses in the Metropolitan Area. Remarkable teachers and other professionals who wish to work in Special Education, however, should not be turned away by a narrow and over-literal construction of the certification rules by overlooking those with outstanding records and qualifications. The Task Force emphasizes some prime qualifications for Special Education teachers and other professionals not generally found in conventional job descriptions:

—The ability to communicate effectively with regular teachers, parents, and children.

—The ability and willingness to function as a member of a team opeartion.

—A tolerance for the frustrations and ambiguities of a large school system with all of its inevitable quirks, deadfalls, and petty politicking.

—The know-how and ability in certain Special Education posts to direct group-oriented techniques and other "systems" psychological work.

—The acceptance of the importance of thinking and acting in terms of the child's home and neighborhood environment, as well as of the child's school environment.

It is recommended that.—

- Teacher certification requirements in Special Education be updated to 18 semester hours, to include a 6-hour supervised practicum with exceptional children.

- A high standard of certification be maintained, with an insistance on attracting persons committed to the education of handicapped children.
- A committee with representation from the Departments of Instruction and Special Education be established to set performance standards for special education personnel.
- Suitably trained counselors be available in each elementary and secondary school as the first and primary contact for the classroom teacher in the initiation of the referral process.
- Priority consideration be given to proposals for the recruitment of special education staff, including the allocation of a minimum of $3,000 for this purpose.

IV. INSTRUCTION AND PUPIL PLACEMENT

Conclusions

There is sufficient evidence from interviews and testimony of teachers and parents, from previous studies and working party reports, from records of various evaluation centers, etc., that there are large numbers of youngsters in many classrooms who are not developing potentialities optimally for a variety of reasons. It is the contention of this subcommittee that services to special education children should begin and if possible end in the regular classroom; that special services including self-contained classrooms, residential placement, and supportive programs act as supplementary devices to augment the regular program. There is a pervasive need for recasting special educational programs and for a reorientation of staff members toward appropriate concepts for the development of exceptional children.

Instruction

It is recommended that:

- A program be established of differentiated staffing for teachers and related staff with the goal that there be at least one educational assistant to each classroom.
- Teachers and other professional staff be provided direct technical supervision at least once a month and that peer group evaluations be conducted system-wide.
- Non-professional aides receive a special orientation and a comprehensive career-oriented training program.
- Staff be trained in the skill of case recording procedures and the use of instruments for needs assessment.
- Centers be established to provide training in homemaking skills, family family management, child rearing, personal care, work habits, and community living for exceptional children.
- Resource center funding be sought (Sec. 621(a) Education of the Handicapped Act.) to meet special needs of the handicapped.
- Adequate counseling services be available to all children.
- Vocational training programs and sheltered workshops be expanded.
- Selection of material for instruction be determined by teachers and appropriate staff personnel in a coordinated fashion combined with the flexibility of the teacher to devise techniques and materials for instruction.
- There be a strong emphasis on Black experience in the instructional program.
- Instructional devices and technical equipment be upgraded, and utilized as appropriate to the needs of the individual child.
- Flexible scheduling be implemented.
- Appropriate activities be provided for children with health problems (not severe enough for Sharpe) when physical education is inadvisable.

Evaluation

It is recommended that.—

- Follow-up procedures be established and records maintained with information to be communicated between concerned departments and community agencies.
- A mandatory, comprehensive, and continuous assessment of all children and provisions be available for periodic feedback to parents, teachers, principals, and other supervisory staff.
- A special education cumulative record be established for each pupil to include the following:
  - —Medical examination and history;
  - —Social work history;
  - —Nutritional patterns;
  - —Psycho-educational information.

Placement

It is recommended that.—

- A special education curriculum guide be established and implemented by September 1972.
- The Department of Special Education be the principle placement agency for all children found to be exceptional.
- Special education children have opportunities to interact with their more normal peers to stimulate achievement and promote social competencies.

V. SPECIAL SERVCIES

Conclusions

The current facilities and programs for the disagnosis and continuing evaluation of children in need of special learning assistance are completely inadequate. Also, there is much confusion expressed by staff of responsibilities between the Department of Special Education and other D.C. agencies. The D.C. Public Schools have stated their responsibility in improving the mental health program of children as a shared one with other community human service agencies. However, they stress the need for reassessment of the essential requirements of the program. Additionally, the inconsistency in job qualifications, performance expectations, or role definitions for the conuseling staff, in conjunction with the absence of in-service training opportunities and inadequate supervision, result in ineffectual job performance. Attention has also been focussed on the lack of overall coordination in the planning of bus transportation, a service completely outside the jurisdiction of the Department of Special Education.

Diagnostic and Evaluative Services

It is recommended that.—

- The Special Education Department would take charge, not only of intake and placement, but also of organizing educational services, * * *.[1]
- The Department of Special Education establish a set of specific procedures for processing and follow-up of each referral, for conferring with parents, and for issuing necessary reports.
- The Department of Special Education devise a progress chart for each child to serve as a cumulative record.
- The Department of Special Education utilize contract services of diagnostic centers with other agencies by accepting their reports and processing them according to established procedures.
- The Associate Superintendent provide for direct referrals from medical personnel, diagnostic centers, community health resource agencies and others.
- A functional liaison be established with the Health Department.
- Bus transportation be arranged by assignment of a liaison to special education to assure the timely delivery of pupils at designated sites and that buses be available for special occasions.

Medical and Dental Services

It is recommended that.—

- Diagnostic studies of children in the public schools be extended to Lead Poisoning, Iron Deficiency, and Sickle Cell Anemia.
- Clarification and formulation of policies, procedures, and areas of responsibility for healthcare of children be established and directed by the Department of Special Education, in conjunction with the Department of Human Resources.
- The first week of the school year be utilized for gross screening for visual and auditory defects and for other educational studies and conferences (parent-teacher) in order to plan appropriately for individual pupil needs and placements.
- The Department of Special Education coordinate information concerning pre-school children from programs such as Project Head Start and the High Risk Infant Clinic in order to plan for the earliest appropriate pre-school placements.
- The Department of Special Education enlist the help of volunteer physicians and dentists through the various medical and dental organizations, schools, and the military.
- Medical and dental consultants be assigned to the Department of Special Education, each for ½ time as minimal.

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[1] Excerpt from Passow Report, 1965–66.

Mental Health Services

It is recommended that.—

- An appropriate mental health program be established to provide services to children, their families, and to the Department of Special Education.
- Adequate psychological, psychiatric, sociological consultants service be made available.

Counseling Services

It is recommended that.—

All parents be strongly urged to participate in counseling sessions as part of the admission process.

Transportation Services

It is recommended that.—

- The position of Transportation Officer for Special Education be established to carry liaison functions.
- A series of orientation sessions as well as periodic training sessions be planned for bus drivers an aides to assist them in learning safety rules and the multiple facets of their assignments.

Lunch Services

It is recommended that.—

- Free lunches be provided for all handicapped students without regard to parent income.

VI. STAFF DEVELOPMENT

Conclusions

A persistent, overriding concern evidenced in interviews, testimony, newspaper reports and previous study group reports has been the quality of teaching and teachers in the Special Education programs. Reported weaknesses in university preparation and in certification licensing requirements have been very disturbing. A major area of deficit that is a key to effective programming is the ability to assess children's learning problems through *educational* testing. Much of this can be done by training classroom teachers in these techniques.

If individualized diagnostic teaching and multi-sensory approaches are to be stressed, then personnel in charge of orientation and inservice training must employ these methods with teachers. If a major goal is to gain the maximum participation and involvement of children with subject matter, then training sessions for teachers need to be programmed to achieve these same goals.

It was the purpose of this subcommittee to examine the evidence and consider some techniques whereby this present staff, given its present limitations of background, might be provided with the upgrading of skills and knowledge to meet the challenges inherent in the proposed new emphasis in Special Education.

Orientation

It is recommended that.—

- A planned full-day orientation to the philosophy and goals of the Special Education Department be held for all personnel, teachers, and paraprofessionals each year.
- A handbook containing policies, practices, and departmental objectives be developed and issued to all members of the Department of Special Education.
- A major effort be made to inform *all* personnel in the D.C. Public Schools of the philosophy and goals of the Special Education Department.

In-Service Training

It is recommended that.—

- All staff development meetings, workshops, and institutes have specific written objectives and be evaluated in terms of stated objectives.
- A sequence of in-service experiences for each year be planned by the Department of Special Education allowing sufficient leadtime for implementation.
- Special education teachers be brought into contact with the most qualified professionals working in the field of special education through a planned consultant program.
- A data bank be established listing outstanding specialists and their contribution to special education.
- The Superintendent of Schools develop and present a plan to the Board which allows the equivalent of ½ day per week for in-service training, and staff development programs.
- Training in educational assessment be a major focus of the in-service program.

VII. SPECIAL EDUCATION AND THE COMMUNITY

Conclusions

Noticeable polarity exists between the Department of Special Education and the Community. In fact there has been a consistent lack of community contact and involvement. Investigation has revealed few, if any, cooperative special education/community projects and no systematic departmental information dissemination process. Much of the difficulty could be eliminated or at least diminished through a stronger school/home relationship program. That is, a more structured—more defined home support system should be developed to: (1) utilize parents in a reinforcement manner; (2) gain valuable knowledge about the child in the home setting; and (3) get the parents help in individual child program development.

It is important that the community be involved in special education at the planning, development, and evaluating levels. Another critical area of concern is legislation for the handicapped. Community pressure as lobbyists "On the Hill", as consultants and planners could do much to provide clout and support for special education.

Parent and Adult Information

It is recommended that.—

- Outreach agencies (Urban League, NAACP, UPO, etc.) have clearly delineated information relating to process, application, mechanics, etc., of grants and services in special education needs.
- Dissemination of information seek to include all community facilities which have a direct relationship to the Department of Special Education.
- Spot announcements on TV, radio, and all other communication media be utilized to make special education services known to the citizenry at large.
- The Division of Special Educational Programming include an Information Center for Handicapped Children with functions such as:
    - —The Center be staffed to permit an ombudsman role, as advocate for the parent and child, with sufficient independence to permit exposing obstacles, gaps or irritants in order to get what the child needs.
    - —A community-school coordination element to inform the community about special programs and rights of children to special education, with concentrated effort on reaching inner-city parents.
- Community Aides be hired in the Division of Special Educational Programming for the expressed purpose of working with the community and professionals in their area.

Citizen Participation in Decisionmaking

It is recommended that.—

- Any and all advisory committees in existence be dissolved and the Task Force on Special Education be reconstituted to form an advisory committee to the Department of Special Education, which will include parents, teachers, and other professionals to encourage more citizen participation in decision-making and implementation.
- From this group an executive committee be formed (not in excess of 7) to monitor recommendations and implementation.

Inter-Group Relationships

It is recommended that.—

- Appropriate liaison be established with all the agencies whose area of major function relates to servicing special needs of youth including: medical, educational, mental health, and other human resources.
- The Special Educational Programming Division should serve the initial leadership role in self actualization and community understanding.

VIII. PRIMARY AND SECONDARY INTERVENTION

Conclusions

There is no pre-school screening and diagnosis in the D.C. School System and yet, surrounding jurisdictions have successfully operated such programs. The lack of adequate in-school screening programs of the D.C. Public Schools prevent proper detection of children with handicapping conditions. A successful screening program requires responsive and available resources to meet and treat the children detected. Currently, non-public schools specializing in teaching or training handicapped children have been relied upon to carry the responsibility of providing quality programs. But, these schools can only serve a limited number of children with literally hundreds of D.C. Public School children on waiting lists.

It is recommended that.—

- Plans be developed and funds sought to initiate an early intervention program operated with the cooperation of the D.C. Department of Human Resources and the Department of Special Education.
- Additional funding of an estimated minimum of $250,000 be included in the next supplemental budget request to provide for personnel and programs.
- Required funds be sought directly from H.E.W. to provide for an adequate in-school screening program.
- The Superintendent of Schools through the Board of Education direct a letter to the Mayor requesting an estimate from the Department of Human Resources as to the annual funding requirement to carry out such a program.
- Ways be sought by the Department of Special Education to meet immediate and continuing educational needs of those children on waiting lists.

Summary

The Task Force has, in the course of its work, established the fact that there is a massive deficiency of services for exceptional children in the D.C. Public Schools. Literally thousands of children are not receiving the education they need. This is the result of widespread inadequacies in the impetus of the educational system and the attitudes of apathy in the community at large.

The Task Force has made a number of specific recommendations toward mitigation of the circumstances contributing to the cycle of longstanding neglect of the children in our city. We feel that the matter of excellence in education and delivery of supportive services is of the greatest urgency and highest priority. It demands immediate implementation.

This Task Force refuses to be engaged in another exercise in futility and will not abandon its charge until there is a positive response to the problem.

Law Digest: Education of Handicapped Children

DISTRICT OF COLUMBIA 51-1 (OCTOBER 1971)

Right to an education

Compulsory Attendance Law: All children between the ages of seven and 16 are subject to the compulsory education requirements. (*Sec. 31-201 Rev. Stats.*)

The District of Columbia board of education may issue a certificate excusing a child from attendance if the child is found mentally or physically unable to profit from attendance in school, upon examination ordered by the board. If the examination shows that the child may benefit from specialized instruction adapted to his needs, he shall attend IF such instruction is available. (*Sec. 31-203 Rev. Stats.*)

Population

Statutes contain no specific provisions for the handicapped in this area.

Identification and placement

Census: The commissioner of education is directed to ascertain the number of blind children and deaf children resident in schools in the District of Columbia over the age six and under age 18. (*Sec. 4864 Rev. Stats.*)

Administrative Responsibility

Special education in the District of Columbia is under the supervision of the board of education. (*Public Law, 254, Organic Law of 1906, Sec. 2*)

Planning

Statutes contain no specific provisions for the handicapped in this area.

Finance

Statutes contain no specific provisions for the handicapped in this area.

Administrative Structure and Organization

Statutes contain no specific provisions for the handicapped in this area.

Services

Statutes contain no specific provisions for the handicapped in this area.

Private

Statutes contain no specific provisions for the handicapped in this area.

Personnel

Statutes contain no specific provisions for the handicapped in this area.

Facilities

Statutes contain no specific provisions for the handicapped in this area.

"Special Education—A Proposed Model Law" by National Association for Mental Health, 1800 North Kent Street, Arlington, Va. 22209

National Association for Mental Health, November 1970

Special Education: A Proposed Model Law

PREFACE

In introducing this model law, the NAMH Council on Childhood Mental Illness urges you to use this as a guide in examining your state's educational law(s) for handicapped children.

The Council wishes to express its reservations in placing "special" children in "special" classes merely to receive funding from the state Board of Education and cautions the Divisions to be aware of this. The Council urges early or partial return to regular classes.

INTRODUCTION

The basic philosophy of the model law on special education for handicapped children is what is supposed to be, at least in theory, universally accepted in our society. This is the basic right of all children to an effective, free public education commensurate with their needs. For too many of those children with handicaps in our society, however, such education has not been and is not now available. The handicapped individual, whether he be a child or an adult, is in reality a second class citizen, excluded from many of the opportunities that most of us take for granted. Because of this, the handicapped child and his family need more help than is currently available in most communities to obtain the special educational services to which the child is morally entitled.

The purpose of the proposed model law is to develop a statutory model that would provide special education for the emotionally disturbed and mentally ill child. However, if the provisions of any law providing comprehensive special educational programs for children with a specific type of handicap are studied, it becomes obvious that these same statutory provisions can be used to provide similar programs for children with other types of handicaps. Equally important, these provisions can be used to provide programs for those children having multiple handicaps. It does not make sense, then, to limit the model law to educational services for the emotionally disturbed and mentally ill child only. The model law, as developed here, is an *omnibus* statute covering special educational programs for all types of handicapped children and providing these children with the individualized programs they need to develop their maximum potential.

Special education programs are expensive. In the past, the cost has seriously limited the number of special programs and the number of children serviced by these programs. Individual communities with their acute financial problems need assistance to enable them to develop adequate programs. Communities also need to be pushed into providing these programs since the permissive approach has not been effective in the past. With this in mind, we are proposing a *mandatory* law.

A comprehensive law on the subject of special education for the handicapped child should: 1) cover all types of handicaps, 2) provide effective, comprehensive, and flexible programs for the several types of handicaps, and 3) be flexible enough to allow for the application of new Knowledge and techniques without requiring changes in the law itself. We have included these provisions in the model law. To provide flexibility, considerable latitude has been given to the State Board of Education in the establishment of suitable regulations.

In developing a model law which can be used, with certain modifications, in any of the 50 states, there are a number of considerations. Primary among these is the fact that existing statutes, while fragmentary, vary substantially among the several states. Existing services for handicapped children also vary significantly between states. It is not the intent of the proposed legislation that any existing services be eliminated. There are too few of these services now. Rather these existing services should be included in their present form, if compatible with the intent of the model law, or modified to fit with the proposed model. Terminology used in the various states also varies as does the format for existing state statutes. The terminology used in the model law is representative of certain particular states and should be self-explanatory. It must be modified to conform with the terminology used in any given state. For instance, the term "regional" is used to describe a school district. In some states other terms such as "consolidated," "county," "parish", etc., would be used.

It is important that the existing statutes on the subject of special education in any particular state be thoroughly studied before attempting to adapt the model law to this particular state. Existing statutes should be included where appropriate, repealed if necessary, or modified as required to make them compatible with the model law.

The model law contains 18 sections. The first 16 sections constitute the permanent portion of the law. Sections 17 and 18 provide for the inital funding and establish the date of implementation. These sections are necessary only for the initial implementation of the law. Based on the general philosophy already outlined, the model has been developed in a specific, comprehensive fashion. Each of the 18 sections has an individual statement of purpose which indicated the specific provisions intended to be provided for under that section. These statements of purpose are not, of course, part of the model law itself.

The model special education law uses the following format:

A. State Board of Education

Section 1. Protects the rights of persons benefiting from special education services.

Section 2. Defines the responsibility and authority of the State Board of Education.

Section 3. Provides that the State Board of Education is the coordinating agency in matters of special education.

Section 4. Establishes a Bureau of Special Education to coordinate activities within the State Department of Education.

Section 5. Establishes an Advisory Council on Special Education within the State Department of Education.

B. Definitions

Section 6. Defines the several kinds of handicapped children included under the act and defines special education.

C. Children and Services

Section 7. Provides for identification of children by local school districts, for the prescription of educational services to fit each child's individual need and for the periodic review of both evaluation of each child and his educational program.

Section 8. Defines the special education programs required and allows alternatives for the local schools in providing them.

Section 9. Provides for vocational and rehabilitation programs.

Section 10. Provides for a program of parent education to improve school-home coordination.

Section 11. Provides a formal review and appeal procedure to protect both the child and the school system.

D. Personnel Training

Section 12. Provides graduate and under-graduate teacher and other personnel training scholarships in special education.

E. Financial Aid

Section 13. Defines the items used to calculate the reimbursible cost of special education.

Section 14. Provides the formula for state aid to special education and the method of payment.

Section 15. Provides construction grants for cooperative or regional special education facilities.

Section 16. Allows state or local boards of education to receive gifts to be used for special education.

F. Implementation

Section 17. Appropriates the monies required by the state for the initial fiscal period to implement special education.

Section 18. Establishes the effective date for implementation of special education.

Section 1: Rights of Citizenship Protected. A finding of entitlement to, or need for, a particular special education program shall not, of itself, operate to create the status of "incompetency", or serve as a basis of exclusion from any benefit, entitlement or right of citizenship to which the person would otherwise be entitled.

Purpose.—To protect persons identified as eligible or special education services from exclusion, by that fact alone, from any benefits or rights of citizenship to which otherwise entitled.

Section 2: State Supervision and Responsibility. The State board of education shall provide for the development and supervision of the educational programs and services for children requiring special education. Said board shall have the authority (a) to make regulations to implement the provisions of this act; (b) to provide and establish standards for the education or special education of all children in institutions operated by the state; (c) to supervise the educational interest of all children requiring special education in any private child-caring institution, school, nonprofit organization, or other facility within or outside of the state; and (d) to establish, maintain, and operate necessary facilities not otherwise established.

Purpose.—To define the responsibility and authority of the state board of education in developing and supervising special education programs in the public schools and protecting the interests of those children requiring special education.

Section 3: Coordination Agency. The state board of education shall be the agency for cooperation and consultation with federal agencies, other state agencies, and private bodies on matters of public school education of children requiring special education, reserving to other agencies their full responsibilities for other aspects of the care of such children.

Purpose.—To identify the state educational agency responsible for coordination with federal and other agencies of matters involving special education in the public schools.

Section 4: Bureau of Special Education. (*a*) There shall be established, within the state department of education, a bureau of special education. Said bureau shall be responsible within said department for the development and supervision of educational programs and services for children requiring special education and shall develop for approval by the state board of education regulations and standards as required to carry out the provisions of this act. (*b*) Said bureau shall be responsible within said department for the supervision of the educational programs of all children requiring special education who are residing in or attending any public institution or any private child-caring institution, school, nonprofit organization, or other facility within or outside of the state. (*c*) Said bureau shall be responsible within said department for review and appeal hearings as provided in Section 11 of this act. (*d*) Said bureau shall have the responsibility within said department for maintaining and reviewing all records as required under Sections 1 to 16, inclusive, of this act. (*e*) Said bureau shall provide professional consultants qualified in the several areas of knowledge necessary for the education of educationally handicapped children.

Purpose.—To provide within the State Department of Education a section with specific responsibility for the education of handicapped children.

Section 5: Advisory Council on Special Education. (*a*) There shall be an advisory council on special education to the state board of education. Said advisory council shall be comprised of not more than 15 members, excluding the representative of the state board of education who shall serve as an ex-officio member without vote. Said council shall elect a chairman from among its members annually. (*b*) On or before———the state board of education shall appoint for terms of one year, seven members of the advisory council on special education and for terms of two years, eight members of said advisory council. Thereafter, all members of said advisory council shall be appointed for terms of two years each. Such advisory council members shall be lay citizens and professionals who have a major concern for the education of educationally handicapped children. (*c*) The advisory council on special education shall meet at least four times each year, and shall study, evaluate, and prepare recommendations on any matter referred by the state board of education or on any other pertinent matter. Said advisory council shall submit a written report of its activities and findings annually to the state board of education. The state board of education shall assist said advisory council in obtaining any appropriate information and date which will enable said advisory council to carry out the functions carried out herein. (*d*) Members of the advisory council on special education shall recieve no compensation for their services, but shall be reimbursed for any expenses encurred in the performance of their duties.

Purpose.—To provide within the State Department of Education an Advisory Committee on Special Education composed of both concerned citizens and professionals to study and evaluate the effectiveness of special education programs.

Section 6: Definitions. For purposes of this act, (a) "Special education" means special classes, programs, services, or training designed to meet the educational needs of educationally handicapped children. (b) "Child" means any person under twenty-one years of age. (c) An "educationally handicapped child" means a child who deviates either intellectually, physically, socially, or emotionally so markedly from normally expected growth and development patterns that he is or will be unable to progress effectively in a regular school program and needs a special class, special instruction, special services, or special training. (d) "Children requiring special education" includes any educationally handicapped child who is mentally retarded, physically handicapped, hearing impaired, blind, socially and emotionally maladjusted, neurologically impaired, perceptually impaired, or suffering any other identifiable learning disability which impedes his rate of development, or any combination of such conditions. (e) A "mentally retarded child" means an "educable" or "trainable" mentally retarded child who, by reason of retarded mental development, is not capable of fully profiting from the regular educational programs of the public schools and requires special education. An "educable mentally retarded child" means one who, at maturity cannot be expected to attain a level of intellectual functioning greater than that commonly expected from a child of twelve years of age but who can be expected to attain a level of intellectual functioning greater than that of a seven-year-old child. A "trainable mentally retarded child" means one who, at maturity, cannot be expected to attain an intellectual functioning greater than that commonly expected of a seven-year-old child. (f) A "physically handicapped child" is one who, because of some physical handicap, is not capable of fully profiting from the regular educational programs of the public schools and requires special education. (g) A "hearing-impaired child" is one who, because of deafness or a severe hearing loss, is not capable of fully profiting from the regular educational programs of the public schools and requires special education. (h) A "blind child" is one who, because of severe visual impairment is not capable of fully profiting from the regular educational programs of the public schools and requires special education. (i) A "socially and emotionally maladjusted child" is one who, because of some serious social, mental, or emotional handicap, is not capable of fully profiting from the regular educational programs of the public schools and requires special education. (j) A "neurologically impaired child" is one who, because of an impairment of the brain or central nervous system, is not capable of fully profiting from the regular educational programs of the public schools and requires special education. (k) A "perceptually impaired child" is one who, because of a serious perceptual impairment, is not capable of fully profiting from the regular educational programs of the public schools and requires special educational programs of the public schools and requires special education. (1) "Learning disabilities" shall be defined by regulations of the state board of education but shall not include any handicap as defined in subsections (e) to (k), inclusive, of this section. (m) "School-age children" are those who have attained the age of five years or that age at which they would normally be eligible for kindergarten programs, whichever is younger.

PURPOSE: To define the various types of handicaps, special educational services and children involved in special education.

Section 7: Identification and Prescription of Services. (*a*) The board of education of each local or regional school district shall identify all children requiring special education within its jurisdiction, maintain records of all such children and shall make such reports as the state board of education may require. The board of education of each local or regional school district shall make provision for all professional services necessary for making a diagnosis and evaluation of each such child requiring special education and for prescribing to said board suitable educational programs for each such child. (*b*) The board of education of each local or regional school district shall review, at least once each year, the diagnosis, evaluation and educational programs of each child requiring special education. The board of education of each local or regional school district shall make provision for all professional services necessary for making such a review and for prescribing to said board any changes required in the educational programs for each such child. (*c*) No child shall be excluded or exempted from special education and no local or regional school district shall be relieved of responsibility for the education of any child except with the express approval of the state board of education upon appropriate professional advice. Said board shall make recommendations, upon appropriate professional advice, for suitable placement of any child so excluded or exempted, shall assist in any appropriate manner to assure the child receives adequate care, and shall maintain records of all such children and their placement. Said board shall review the record of each such child annually to ascertain whether said child is (1) receiving services appropriate for his needs, and (2) if the exclusion or exemption of said child from public school programs should be continued.

PURPOSE.—To provide for the identification of all children requiring special education in each school district.

To provide an educational diagnosis and evaluation for each child.

To provide a prescription of educational services appropriate to each child's individual need.

To provide a periodic review of the diagnosis and evaluation of each child.

To control the exclusion or exemption of children requiring special education from school privileges.

To provide for suitable placement for any child excluded or exempted from school privileges.

To provide a periodic review of both the placement and the exclusion or exemption from school privileges.

Section 8: Special Education Programs and Services. (*a*) Each local and regional school district shall provide appropriate special education for school-age children requiring special education. The obligation of the local or regional school district under this subsection shall terminate when such child is graduated from high school or reaches age twenty-one, whichever occurs first. (*b*) Each local and regional school district shall provide appropriate special education for children requiring special education who have not attained school age but whose educational potential will be substantially increased by special education at an early age. The state board of education shall define the criteria by which a local or regional school district shall determine whether a given child is eligible for special education pursuant to this subsection (*b*), and such determination shall be made by the school district when requested by a parent or guardian, or upon referral by a physician, clinic, psychologist, social worker or other professional, provided the parent or guardian so permits. (*c*) Any local or regional school district may combine with one or more other local or regional school districts to provide such special education or may provide such special education in another local or regional school district by payment of tuition. (*d*) Each local or regional school district providing special education for children requiring special education pursuant to the provisions of subsections (a) to (c), inclusive of this section, shall provide transportation for each such child receiving such special education. (e) Any town or regional school district shall, with the consent of the parent or guardian of a child requiring special education and with the approval of the state board of education, provide for such special education for said child in a private school or public or private institution within or outside of the state, when appropriate special education is not available in the public schools of the said school district or in another local or regional school district. Each local or regional school district providing special education pursuant to the provisions of this subsection (*e*), shall provide tuition, transportation, room and board and other items relevant to the education of each such child. (*f*) Each local or regional school district shall provide for appropriate special education for school-age children requiring special education who, because of medical, psychiatric, home situation or other non-educational reasons must be placed in a private school or public or private institution even though special education appropriate for such child is available in the public schools of the said school district or in another local or regional school district. Each local or regional school district providing special education for children requiring special education pursuant to the provisions of this subsection (*f*), shall provide special educational services as defined in regulations established by the state board of education. Said special educational services shall not include board and room, therapy or other non-educational costs.

Purpose.—To provide mandotory special education for all educationally handicapped children of school age.

To provide mandatory special education for those pre-school educationally handicapped children who require the special educational services at an early age.

To allow school districts to combine or work cooperatively to provide special education.

To allow school districts to use private schools, or other available resources to provide special education in those cases it is not practical to provide special education in the public school system.

To make local or regional school districts responsible for the educational needs of those children who must be institutionalized for other than educational reasons.

To require school districts to provide transportation for all children requiring special education.

Section 9: Rehabilitation Services. (*a*) Any local or regional school district, with the consent of the parent or guardian of a child requiring special education and with the approval of the state board of education, may enter into a contract with any sheltered workshop, rehabilitation center, or other agency in order to provide an educational occupational training program for said child, provided said child is fourteen years of age or over. (*b*) Each local or regional school district shall provide transportation for each such child attending such educational occupational training program.

Purpose.—To provide vocational training and rehabilitation services for those children requiring special education who require these types of services.

Section 10: Parent Counseling. Any local or regional school district may develop and provide, with the approval or the state department of education, a program of education and counselling for parents of children receiving special education as provided by said district. Said program shall be for the purpose of assisting and improving the educational development of such children.

Purpose.—To assist parents in understanding their handicapped children so they can effectively cooperate with the public school special education program.

Section 11: Review and Appeal Procedure. (*a*) A parent or guardian of an educationally handicapped child or the board of education responsible for providing special education for such a child, with due cause, may request in writing to the state board of education, a review of: (1) diagnosis, (2) evaluation of educational programs provided for such child by the local or regional board of education, or (3) the exclusion or exemption from school privileges of such child by the local or regional board of education. (*b*) The state board of education shall, on receipt of request for such review, establish a hearing board of not less than three persons knowledgeable in the fields and areas significant to such educational review of said child. Members of the hearing board may be employees of the state department of education or may be qualified persons from outside said department. No person who participated in the previous diagnosis, evaluation, prescription of special educational services, and other educational records of said child, which records shall be furnished by the local or regional board of education, and may hear such additional testimony as the hearing board shall deem relevant. Said board may require a complete and independent diagnosis, evaluation and prescription of educational programs by qualified persons, the cost of which shall be paid by the state board of education. (*d*) The hearing board shall have the authority to confirm, modify, or reject any diagnosis, evaluation, educational program prescribed or exclusion or exemption from school privileges and prescribe alternate special educational programs for the child. Appeal from the decision of the hearing board shall be to the (***appropriate***) court in the district of residence of said child. (*e*) Members of the hearing board, other than those employed by the state department of education, shall be paid reasonable fees and expenses as established by the state board of education.

Purpose.—To provide a formal review and appeal procedure at state level, prior to referral to the courts, to protect the child from inadequate or inappropriate educational services and to protect the school system from unreasonable demands by parents

Section 12: Training of Professional Personnel for Children Requiring Special Education. (*a*) Annually, on or before July first, the state board of education shall determine those areas of special education in which shortage of professional personnel exists. (*b*) The state board of education may provide scholarship aid, in an amount determined by said board and subject to appropriations therefore, for graduate or undergraduate students in any area of special education in which said board has determined a shortage of professional personnel exists under provisions of subsection (*a*) of this section. (*c*) Applications for scholarship aid shall be made in accordance with procedures established by the state board of education and to be eligible for such scholarship aid any applicant shall attend a program approved by said board in an institution within or outside of the state and said applicant shall agree to teach children requiring special education in (***state***) for at least three years.

Purpose.—To provide financial assistance to stimulate and encourage the training of teachers and other professional personnel needed for the growing field of special education.

Section 13: Definition of Terms Used in Formula for State Aid for Special Education. For purposes of reimbursement under Section 14 of this act, (*a*) "Special education personnel" includes any person engaged in special education, or any person being provided training in identifying, handling or educating educationally handicapped children, in accordance with sections 1 to 16, inclusive, of this act. (*b*) "special education equipment and materials" means such equipment and materials as are used primarily to implement special education in accordance with sections 1 to 16, inclusive, of this act. (*c*) "Special education tuition" means the tuition, board, room and other fees paid to another public or private school, public or private agency or institution by a board of education to meet the educational needs of children requiring special education as provided in sections 1 to 16, inclusive, of this act. (*d*) "Special education transportation costs" are the amounts paid by a claimant local or regional board of education for transporting any child to and from any clinic, physician's office, agency or institution to which the board requests the child to go for the purposes of determining the need for special education and amounts paid for transporting such child to and from any school, agency or institution for the purposes of special education. (*e*) "Special education rent" means any expenditure for rental of space or equipment to implement special education in accordance with sections 1 to 16, inclusive, of this act. (*f*) "Special education consultant services" means non-instructional services rendered, concerning children requiring special education, by professional persons other than employees of the local or regional board of education for programs approved pursuant to said sections 1 to 16, inclusive, of this act. (*g*) "Net cost of special education" means the result obtained by subtracting from the expenditures made by a claimant board for special education personnel, equipment and materials, tuition, transportation, rent, and consultant services, the total amount of any funds from other state or federal grants, private grants or special education tuition received by a claimant board in such year and used to implement special education programs approved pursuant to sections of this act.

PURPOSE.—To define those items involved in providing special education programs and services that are included in the costs being reimbursed by the state.

Section 14: State Aid for Special Education, (*a*) Each local or regional school district which provides special education, in accordance with sections 1 to 16, inclusive, of this act, for any educationally handicapped child shall receive a grant equal to seventy-five per cent of its net cost of special education. Applications for such grants shall be made to the state board of education by such local or regional school district at such time and in such form as said board may designate, and such grants shall be payable in two installments the first not later than the first day of October and the second not later than the first day of February in such school year, the first installment to be in an amount equal to fifty per cent the estimated cost of such special education for such school year, subject to adjustment to the actual net cost of such special education at the end of such scholo the estimated cost of such special education for such school year, subject to adjustment to the actual net cost of such special education at the end of such school year, and he second installment to be in an amount equal to twenty-five per cent of the total net cost of such education for such school year subject to the same adjustment. (*b*) The state board of education shall periodically review and audit grant payments authorized under this section of this act in order to determine actual net cost of the special education for which such payments are made. Within sixty days after the close of each school year, any local or regional school district which has received a grant under this section of this act shall file a financial statement of expenditures in such form as the state board of education may prescribe. If the state board of education finds that the grant exceeds seventy-five per cent the actual net cost of special education, said board shall require repayment of such funds to the state.

Purpose.—To provide state financial assistance to local and regional school districts for special education programs and to prepay such assistance to minimize the financial impact involved in the development of an effective program of special education.

Section 15: State Grants for Special Education Facilities. Any local or regional school district which agrees to provide special education, as part of a regional or cooperative plan approved by the state board of education, for children requiring special education for one or more other local or regional school districts shall be eligible to receive a grant in an amount equal to the net cost to such school district of providing, constructing or reconstructing and equipping appropriate facilities to be used primarily for children requiring special education. Said facilities shall be approved by the state board of education and shall be adjunct to or connected with facilities for children in the regular school program, except when the state board of education determines that separate facilities would be of greater benefit to the children participating in the special education program. Applications for grants under this section shall be made to the state board of education at such time and in such manner as said board may prescribe. Said board may make such a grant in a lump sum in an amount equal to one hundred per cent of the cost of the facilities less any other public or private grants for such purpose.

Purpose.—To encourage the development of the regional or cooperative approach to special education, especially in smaller communities, by providing construction grants for facilities and to encourage these facilities, and the special education programs in them, to be part of the regular public school setting.

Section 16: Receipt and Use of Money. The state board of education or the board of education of any local or regional school district may receive money, securities or other personal property by gift, devise or bequest to be used for the education of children requiring special education in accordance with provisions of sections 1 to 16, inclusive, of this act and the wishes of the donor.

Purpose.—To permit the local school systems to accept gifts to be used for special education.

Section 17: Appropriation. The sum of ——— dollars is appropriated to the state board of education for the purposes of this act for the fiscal year beginning ———.

PURPOSE.—To provide the funds required to implement the act and fund the initial period of operation of special educational services.

Section 18: Effective Date. This act shall take effect ——— except that expenditures made by a local or regional board of education for special education prior to ——— shall not be reimbursable special education costs under provisions of this act.

PURPOSE.—To establish the date at which the law takes effect and to allow a suitable period of preparation prior to this date. A period of one to two years should be allowed.

"State Law and Education of Handicapped Children: Issues and Recommendations" by The Council for Exceptional Children, 1411 South Jefferson Davis Highway, Arlington, Virginia 22202

State Law and Education of Handicapped Children: Issues and Recommendations

(Frederick J. Weintraub, Alan R. Abeson, and David L. Braddock)

Model Statutes

Every state has a comprehensive school law. It covers the organization and functions of the one or more state education agencies, qualifications for teachers and other school professionals, state-local relations, local public school systems, the role of private schools, and compulsory school attendance.

For normal children, the regular school law is a sufficient and generally all-inclusive legal basis for the free public education they receive or a prescription of the conditions under which they may substitute private schooling.

For the handicapped, supplementary provisions are necessary. Children who have many kinds of physical, mental, emotional, or learning impairments frequently can function in the regular public school setting only if certain aids and auxiliary services designed to ameliorate or overcome the impediments imposed by their handicaps are supplied. In other instances, special environments are needed to enable the handicapped to secure the equivalent of what most children receive entirely from the regular programs or, where this is impracticable, to receive education suited to their conditions and needs. Laws in every state related to special education provide the basis on which the handicapped gain access to the free public education, which is the responsibility of the state to provide.

The following pages contain a comprehensive set of model statutory provisions designed to provide a full legal basis for practicable and effective programs of education for handicapped children. The intention is that they should be considered by states wishing to revise or update their laws relating to the education of the handicapped. Since this group of children is part of the population to which the comprehensive state school law applies and should continue to apply, the models are designed for incorporation into that law.

States considering a major overhaul of their education statutes may wish to regard the models taken in their entirety as a complete set of provisions relating to special education for the handicapped. Other states may wish to consider some of the individual provisions for addition to the existing statutes or as substitutions for particular provisions needing improvement.

The materials are presented in a number of distinct parts. The first of them is brief and applies to all children. It is a compulsory school attendance law in two short sections. It is included because one of the most serious problems in attempting to secure education for the handicapped is the tendency to excuse children with special problems from the requirements of regular school attendance. Statutes which condone or provide for such a course signal a failure of the public educational system to reach large groups of children for which it is intended. In many cases, they also contravene statutory or constitutional provisions which purport to afford education for all.

The other parts are arranged as a title of a comprehensive state school law. This title relates to special education for the handicapped. It does not replace the regular school law but is a supplement to it.

Brackets [ ] are used to set off alternative language or to indicate areas for insertion of appropriate existing state law or policy.

MODEL COMPULSORY SCHOOL ATTENDANCE LAW

Section 1

School Attendance and Instruction Required

All children between the ages of [ ] and [ ] shall attend the public schools, or such other schools as may be approved by the [state education agency] for the purpose of satisfying complusory school attendance requirements, and shall receive instruction therein.

Section 2

Programs of Instruction

(a) No child shall be exempt from the requirements of Section 1 hereof, nor shall the authorities legally charged with responsibility for the education of children be relieved from the obligation to provide suitable instruction. The public school authorities shall provide such special programs of education, corrective and related services as may be appropriate to enable all children of the following classes to meet the requirements of Section 1 of this Act:

1. Children who are unable to benefit sufficiently from the regular programs of instruction by reason of their mental, physical, emotional or learning problems, or for any other reason.
2. Children whose degree or kind of disability or illness precludes attendance in a regular school setting.

(*b*) A child shall be deemed to be of the type described in subsection (*a*) hereof only upon certification pursuant to rules and regulations of the [state education agency] that he is suffering from physical or mental illness or disease of such severity as to make his presence in a school facility or his travel to and from such facility impossible or dangerous to his health or the health of others. For such children, home, hospital, institutional or other regularly scheduled and suitable instruction meeting standards of the [state education agency] shall be provided by the public schools.

TITLE — . EDUCATION OF THE HANDICAPPED

PART I. POLICY

Section 100

Povision and Implementation

It is the policy of this state to provide, and to require school districts to provide, as an integral part of free public education, special education sufficient to meet the needs and maximize the capabilities of handicapped children. The timely implementation of this policy to the end that all handicapped children actually receive the special education necessary to their proper development is declared to be an integral part of the policy of this state. This section applies to all handicapped children regardless of the schools, institutions, or programs by which such children are served.

Section 101

Services Mandatory

The [state education agency] shall provide or cause to be provided by school districts all regular and special education, corrective and supporting services required by handicapped children to the end that they shall receive the benefits of a free public education appropriate to their needs. It shall be within the jurisdiction of the [state education agency] to organize and to supervise schools and classes according to the regulations and standards established for the conduct of schools and classes of the public school system in the state in all institutions wholly or partly supported by the state which are not supervised by public school authorities. Schools and classes so established in wholly state owned institutions shall be financed by the [state education agency].

Section 102

Preference for Regular Programs

To the maximum extent practicable, handicapped children shall be educated along with children who do not have handicaps and shall attend regular classes. Impediments to learning and to the normal functioning of handicapped children in the regular school environment shall be overcome by the provision of special aids and services rather than by separate schooling for the handicapped. Special classes, separate schooling or other removal of handicapped children from the regular educational environment, shall occur only when, and to the extent that the nature or severity of the handicap is such that education in regular classes, even with the use of supplementary aids and services, cannot be accomplished satisfactorily.

Section 103

Facilities

Physical aspects and specifications of schools, classrooms and other facilities for, or likely to be used by handicapped children, shall be related to their special physical, educational and psychological needs. To this end, school districts, [Special Education Services Associations], agencies of the state and its subdivisions, and any private persons or entities constructing, renovating or repairing facilities with or aided by public funds, which facilities are expressly intented for or are likely to be used by handicapped children, shall plan, locate, design, construct, equip, and maintain them with due regard for the special capabilities, handicaps and requirements of the handicapped children to be accommodated therein.

Section 104

Responsibilities

It is the responsibility of local governments and school districts to expend effort on behalf of the education of each handicapped child equal to the effort expended on account of the education of each child who does not have a handicap. Any additional effort necessary to provide supplemental aids and services shall be the ultimate responsibility of the state but shall, to the maximum extent practicable, be administered through the local school districts.

Section 105

Private Programs

The responsibility of local governments, school districts, and the state, to provide a free public education for handicapped children is not diminished by the availability of private schools and services. Whenever such schools and services are utilized, it continues to be the public responsibility to assure an appropriate quantity and quality of instructional and related services, and the protection of all other rights, and to ascertain that all handicapped children receive the educational and related services and rights to which the laws of this state entitle them.

PART II. DEFINITIONS

Section 200

Definitions

As used in this Title:

(a) "Handicapped child" means a natural person between birth and the age of twenty-one, who because of mental, physical, emotional or learning problems requires special education services.

(b) "Special education" means classroom, home, hospital, institutional or other instruction to meet the needs of handicapped children, transportation and corrective and supporting services required to assist handicapped children in taking advantage of, or responding to, educational programs and opportunities.

(c) "School district" means either a school district or a political subdivision operating a public school or public school system.

(d) "Special education facility" means a school or any portion thereof, remedial or supplemental facility or any other building or structure or part thereof intended for use in meeting the educational, corrective, and related needs of handicapped children.

PART III. STATE AND LOCAL RESPONSIBILITIES

Section 300

Establishment of Division

There is hereby established in the [State Education Agency] a Division for the Education of the Handicapped. The Division shall be headed by a Director who shall be qualified by education, training, and experience to take responsibility for, and give direction to, the programs of the [State Education Agency] relating to the handicapped.

Section 301

Advisory Council

(a) There shall be an Advisory Council for the Education of the Handicapped which shall advise and consult with the [head of the state education agency] and the Director of the Division for the Education of the Handicapped, and which shall engage in such other activities as are herinafter set forth. The Advisory Council shall be composed of [9] members who are not officers or employees of State agencies and no more than [4] of whom may be officers or employees of local school districts. The [head of the state education agency] shall appoint the members of the Advisory Council for [3] year terms, except that of those first appointed, [3] shall be appointed for terms of one year, [3] for terms of two years and [3] for terms of three years. Vacancies shall be filled for the unexpired term in the same manner as original appointments.

(b) The Advisory Council shall be composed of persons broadly representative of community organizations interested in the handicapped, professions related to the educational needs of the handicapped, and the general public.

(*c*) The Advisory Council annually shall elect its own chairman and vice chairman. The director of the Division for the Education of the Handicapped shall meet with and act as secretary to the Advisory Council and, within available personnel and appropriations, shall furnish meeting facilities and staff services for the Advisory Council. The [state education agency] shall regularly submit, as part of its budget requests, an item or items sufficient to cover expenses of the operation of the Advisory Council and of its members in connection with their attendance at meetings of the Advisory Council, and other Advisory Council activities.

(*d*) The Council shall:

1. Have an opportunity to comment on rules and regulations proposed for issuance pursuant to this Title.
2. Consider any problems presented to it by the [head of the state education agency] or the Director of the Division for the Education of the Handicapped, and give advice thereon.
3. Review the State Plan prepared pursuant to Section 400 of this Title prior to its submission to the governor and legislature and comment thereon to the [head of the state education agency] and the Director of the Division for the Education of the Handicapped.
4. Make an annual report to the governor and legislature, and [the state board of education] which report shall be available to the general public and shall present its views of the progress or lack thereof made in special education by the state, its agencies and institutions, and its school districts during the preceding year.

(e) Funds for the publication of the report referred to in subsection (d) of this Section shall be made available from the regular appropriations to the [state education agency].

Section 302

Special Education Services Association

A school district may meet its obligations to provide education, corrective, and supporting services for handicapped children, as set forth in this Title, and in any other laws and regulations of the [state education agency], by participating in a Special Education Services Association established and operated pursuant to this Title.

A Special Education Services Association may be the means whereby participating school districts perform all of their special education functions or perform only specified special education functions. In the latter case, participating school districts shall continue to provide special education and related services not provided by such an Association on an individual district basis or in some other manner pursuant to law.

Section 303

Area and Manner of Establishment

A Special Education Services Association shall provide services for all the area included within the school districts participating in it. It may be established by [resolution of each of the governing boards of the school districts participating in it] [by vote of the electors in each of the participating school districts in the same manner as a school bond referendum].

Section 304

Governing Board

The Governing Board of a Special Education Services Association shall consist of representatives of the participating school districts. Unless otherwise provided in a written agreement embodied in the resolutions or propositions by which the Special Education Services Association is established, each participating school district shall have one representative. The representatives of each school district on the Governing Board shall be [elected by the governing board of the school district from its own members] [elected by the voters of the school district]. Each such representative shall have one vote on the Governing Board.

Section 305.

Powers of Governing Board

The affairs of a Special Education Services Association shall be administered by its Governing Board, and the officers and employees thereof. A Special Education Association shall have power to:

(*a*) Establish and operate programs and classes for the education of handicapped children.

(*b*) Acquire, construct, maintain and operate facilities in which to provide education, corrective services, and supporting services for handicapped children.

(*c*) Make arrangements with school districts participating in the Special Education Services Association for the provision of special education, corrective, and supporting services, to the handicapped children of such school districts.

(*d*) Employ special education teachers and personnel required to furnish corrective or supporting services to handicapped children.

(*e*) Acquire, hold and convey real and personal property.

(*f*) Provide transportation for handicapped children in connection with any of its programs, classes or services.

(*g*) Receive, administer and expend funds appropriated for its use.

(*h*) Receive, administer and expend the proceeds of any issue of school bonds or other bonds intended wholly or partly for its benefit.

(*i*) Apply for, accept, and utilize grants, gifts, or other assistance, and, if not contrary to law, comply with the conditions, if any, attached thereto.

(*j*) Participate in, and make its employees eligible to participate in, any retirement system, group insurance system, or other program of employee benefits, on the same terms as govern school districts and their employees.

(*k*) Do such other things as are necessary and incidental to the execution of any of the foregoing powers, and of any other powers conferred upon Special Education Services Associations elsewhere in this Title or in other laws of this state.

Section 306

Special Education Centers

(*a*) A Special Education Services Association may establish and operate one or more special education centers to provide diagnostic, therapeutic, corrective, and other services, on a more comprehensive, expert, economic and efficient basis than can reasonably be provided by a single school district. Such services may be provided in the regular schools by personnel and equipment of a center or, whenever it is impractical or inefficient to provide them on the premises of a regular school, the center may provide services in its own facilities. To the maximum extent feasible, such centers shall be established at, in conjunction with, or in close proximity to one or more elementary and secondary schools.

(*b*) Centers established pursuant to this Section also may contain classrooms and other educational facilities and equipment to supplement instruction and other services furnished to handicapped children in the regular schools, and to provide separate instruction to children whose degree or kind of handicap makes it impracticable or inappropriate for them to participate in classes with normal children.

(*c*) Centers established pursuant to this Section may include dormitory and related facilities and services in order to permit handicapped children who may not reasonably go to and from home daily to receive educational and related services.

(*d*) No facilities may be acquired or constructed pursuant to this Section unless application therefor has been made by the Special Education Services Association to the Division of Education for the Handicapped and a permit for such facilities has been issued by the Division. The permit may contain such conditions as the Division may deem appropriate to assure conformity with the policy of this Title.

No permit shall be issued unless the Division of Education for the Handicapped is satisfied that every effort has been and is being made to accommodate the educational or related services in regular school buildings or on regular school premises, and, that separate facilities are necessary.

Section 307

Relation to School Districts

(*a*) A Special Education Services Association shall provide education, corrective and supporting services for all handicapped children who are residents thereof, except for special education, corrective, and supporting services that are provided direclty by the state, and any special education, corrective, and supportive services as, pursuant to the agreement under which the Association functions, are expressly reserved for continued provision by the individual school districts. To the maximum extent practicable, a Special Education Services Association shall make such provision in the regular schools of the school districts served by the Special Education Services Association or in its own facilities established and operated pursuant to Section 305 of this Title. A Special Education Services Association shall make arrangements with, and payments to, private schools, institutions, and agencies, for services to handicapped children only if it is unable to provide satisfactory service with its own facilities and personnel, and the facilities and personnel of its member school districts.

(*b*) A Special Education Services Association shall provide home or hospital instruction, corrective, and supporting services to handicapped children, but only in cases where the nature and severity of the handicap make the provision thereof in the regular schools, or in other facilities of the Special Education Services Association, the state, or in suitable private facilities, impracticable.

(*c*) A school district may qualify, for the purposes of state aid, as a Special Education Services Association, if it provides a full complement of educational, corrective and supporting services, exclusive of services provided directly by the state, for all handicapped children resident within its boundaries. Upon application made pursuant to Section 308(c) of this Title the [state education agency] shall determine whether the applicant school district meets the requirements of the subsection.

Section 308

Application for Special Education Services Association Status

(*a*) Any Special Education Services Association which is in the process of formation, and which proposes to qualify for state aid, shall submit the interschool district agreement pursuant to which it proposes to function to the [state education agency]. Such submission may be either prior or subsequent to adoption of the agreement and the resolution or proposition required by Section 302 of this Title but not Special Education Services Association shall receive state aid unless it has been approved therefor by the [state education agency].

(*b*) The [state education agency] shall approve a Special Education Services Association for state aid if it determines that:

1. The Association complies with all provisions of this Title, or if the Association is not yet in operation, that it will have the resources and authority to comply therewith.

2. The geographic area served or to be served by the Special Education Services Association is not so located or of such a configuration as to exclude one or more other school districts from effective participation in a Special Education Services Association or from forming a viable Association of their own.

(*c*) A school district may apply for and receive the status of a Special Education Services Association by submitting to the [state education agency] an appropriate resolution of its governing board requesting such status. The provisions of Section 309 hereof shall not apply to an application submitted pursuant to this subsection, but the application shall not be approved unless the [state education agency] finds that the school district complies with subsection (b) 1 of this Section, and that it maintains a full complement of special education facilities and programs.

Section 309

Interschool District Agreement

(*a*) Each Special Education Services Association, other than one composed of a single school district, shall function pursuant to and in accordance with an interschool district Agreement (hereinafter referred to as "the Agreement").

The Agreement may be incorporated in the resolution or other action establishing the Special Education Services Association or may be a separate document. In any case, however, it shall be adopted either by affirmative vote of each of the governing boards of the school districts participating in the Special Education Services Association or by affirmative vote of the electors in each such school district.

(*b*) An Agreement shall contain:

1. A precise identification of the party school districts.
2. An enumeration or other precise delineation of the services to be provided by the Special Education Services Association.
3. Provisions relating to the internal management and control of the Special and the Special Education Services Association in regard to the responsibilities.
4. Provisions defining the relationships between the party school districts and the Special Education Services Association in regard to the responsibilities for regular education of handicapped children and special education, corrective and supporting services for handicapped children.
5. Provisions fixing the financial responsibilities of each party school district to the Special Education Services Association or setting forth formulas, procedures and other specific methods for the calculation thereof.
6. A minimum duration for the Agreement.
7. Provisions for amendment, renewal, withdrawal from or termination of the Agreement.
8. Provisions for the disposition of Special Education Services Association property upon dissolution of the Association.
9. Financial settlement, if any, with a withdrawing school district.
10. Any other necessary or appropriate provisions.

(*c*) Prior to becoming effective, an Agreement shall be submitted to the [state education agency] and the Attorney General, and it shall not go into effect unless approved thereby. Failure to respond to a submission within [90] days shall constitute approval thereof.

(*d*) 1. The [state education agency] shall approve a submitted Agreement, unless it finds that the provisions thereof do not accord with this Title and the policies set forth herein, or unless it finds that the Agreement does not contain sufficient evidence that the Special Education Services Association will have the means of providing the facilities, personnel and services necessary to fulfill its obligations toward handicapped children.

2. The Attorney Generall shall approve a sbumitted Agreement, unless he finds it to be in improper form, or unless he finds one or more of its provisions contrary to law.

Section 310

Contracts Not Prohibited

Nothing in this part shall be construed to prevent a school district from providing educational, corrective, or supporting services for handicapped children by contracting with another school district to provide such services for handicapped children from such other district.

Section 311

Withdrawal and Dissolution

(a) A school district which is included in a Special Education Service Association may withdraw from participation in any part of the Association only with the approval of the Director of the Division for the Education of the Handicapped after he has conferred with the district and is satisfied that such withdrawal is in the interest of the handicapped children in the Association and the school district affected. Such withdrawal shall be effective only if the school board has the approval of the Director of the Division of the Education of the Handicapped to establish a comparable part of a program. Such withdrawal shall not be effective until the end of the next full school year. The withdrawing school district shall be liable for its proportionate share of all operating costs until its withdrawal becomes effective, shall continue to be liable for its share of debt incurred while it was a participant and shall receive no share in the assets.

(*b*) An Association established under this part may be dissolved by action to its governing board, but such dissolution shall not take place until the end of the school year in which the action was taken. When an Association is dissolved, assets and liabilities shall be distributed to all entities which participated in the Association.

PART IV. PLANNING

Section 400

State Plan

(*a*) The [state education agency], acting through its Division for the Education of the Handicapped, shall make and keep current a plan for the implementation of the policy set forth in Part I of this Title. The plan shall include:

1. A census of the handicapped children in the state showing the total number of such children and the geographic distribution of handicapped children as a whole.

2. Provision for diagnosis and screening of handicapped children.

3. An inventory of the personnel and facilities available to provide instruction and other services for handicapped children.

4. An analysis of the present distribution of responsibility for special education between the state and local school systems and general units of local government, together with recommendations for any necessary or desirable changes in the distribution of responsibilities.

5. Identification of the criteria for determining how handicapped children are to be educated.

6. Standards for the education to be received by each of the several categories of handicapped children in regular schools or school districts and in state institutions, including methods of assuring that education afforded the handicapped will be as nearly equivalent as may be to that afforded regular children and also will take account of their special needs.

7. A program for the preparation, recruitment and inservice training of personnel in special education and allied fields, including participation, as appropriate, by institutions of higher learning, state and local agencies, and any other public and private entities having relevant expertise.

A program for the development, acquisition, construction and maintenance of facilities, and new, enlarged, redesigned and replacement facilities needed to implement the policy of this Title.

9. A full description of the state plan for providing special education to all handicapped children in this state, including each of the matters enumerated herein, and any other necessary or appropriate matters.

10. Any additional matters which may be necessary or appropriate, including recommendations for amendment of laws, changes in administrative practices and patterns of organization, and changes in levels and patterns of financial support.

(*b*) The plan required by subsection (a) hereof shall be presented to the Governor and the Legislature and made available for public distribution no later than [—————— ——————]. Thereafter, amendments to or revisions of the plan shall be submitted to the Governor and Legislature and made available for public distribution no less than [90] days prior to the convening of each regular session of the Legislature. All such submissions, except for the initial submission of the plan, shall detail progress made in fulfilling the plan and in implementing the policy of this Act.

Section 401

Local Planning and Responsibility

(*a*) On or before [——], each school district shall report to the [state education agency] the extent to which it is then providing the special education for handicapped children necessary to implement dully the policy of this Title. The report also shall detail the means by which the school district or political subdivision proposes to secure full compliance with the policy of this Title, including:

1. A precise statement of the extent to which the necessary education and services will be provided directly by the district pursuant to law requiring such direct provision.

2. A precise statement of the extent to which standards in force pursuant to Section 400(a)6 of this Title are being met.

3. An identification and description of the means which the school district or political subdivision will employ to provide, at levels meeting standards in force pursuant to Section 400(b) of this Title, all special education not to be provided directly by the state.

(*b*) After submission of the report required by subsection (a) hereof, the school district shall submit such supplemental and additional reports as the [state education agency] may require, in order to keep the plan current. By rule or regulation, the [state education agency] shall prescribe the due dates, form and all other necessary or appropriate matters relating to such reports.

(*c*) For the purposes of this Section, handicapped children being furnished special education in state schools or other state facilities shall continue to be the planning responsibility of the school district in which they would be entitled to attend school if it were not for the direct provision of special education to them by the state. A record of each such child, the nature and degree of his handicap and of the way in which his educational needs are being met shall be kept by the school district.

Section 402

Interstate Cooperation

Any state and local plans made pursuant to this Part shall take into account the advantages and disadvantages in providing special education to particular kinds of handicapped children through cooperative undertakings with other jurisdictions. In addition to any arrangements that may be made pursuant to Sections 302–305 of this Title, the state or school district may enter into agreements with other school districts or states to provide such special education: provided that a child receiving special education outside the school district in which be would normally attend public school shall continue to be the responsibility of such school district and nothing herein shall be deemed to relieve the school district from compliance with the requirements of this Title.

(*b*) Agreements made pursuant to this Section may include the furnishing of educational and related services, payment of reasonable costs thereof, the making of capital contributions toward the construction or renovation of joint or common facilities or facilities regularly made available by one party jurisdiction to the handicapped children of another party jurisdiction, and furnishing of or responsibility for transportation, lodging, food and related living costs.

(*c*) Any child given educational or related services and any parent or guardian of such child, pursuant to this Section and any agreement made pursuant hereto, shall continue to have all civil and other rights that he would have if receiving like education or related services within the subdivision or school district where he would normally attend public school. No agreement made on the authority of this Section shall be valid unless it contains a provision to such effect.

PART V. IDENTIFICATION OF HANDICAPPED CHILDREN

Section 500

Children Attending School

Every school district shall test and examine, or cause to be tested and examined, each child attending the public and private schools within its boundaries in order to determine whether such child is handicapped. The tests and examinations shall be administered on a regular basis in accordance with rules and regulations of the [State Education Agency]. As used in this Part, the term "schools" shall mean kindergartens and grades 1–12 and, if the school district provides educational programs below kindergarten level or above grade 12 to all children attending such programs.

Section 501

Limitation

The requirements of Section 500 shall not apply to children attending private schools, if the children are not residents of this state provided that if the state or the school district had an agreement with another state or school district requiring such tests and examinations, the school district shall administer them and report the results to the school district of the child's residence.

Section 502

Records

Every school district shall make and keep current a list of all handicapped children required to be tested and examined pursuant to Sections 500 and 501 of this Title who are found to be handicapped and of all children who are residents of the school district and are receiving home, hospital, institutional or other special education services in other than regular programs.

PART VI. PROVISION OF SPECIAL EDUCATION MATERIALS AND TRAINING

Section 600

[Unit] Established

There shall be in the Division for the Education of the Handicapped a "Special Education Materials and Training Unit," hereafter called ["the Unit"], for the purpose of assisting in the education of handicapped persons.

Section 601

Functions

In addition to any functions in which it may engage pursuant to other provisions of this Title or other laws, the [Unit] may:

(*a*) Develop, test, demonstrate, maintain, purchase or otherwise acquire, store, produce if not reasonably obtainable from commercial sources, and make available equipment, materials, and special supplies and devices particularly useful in connection with the education of handicapped persons.

(*b*) Study, develop, and disseminate information concerning techniques for teaching handicapped persons.

(*c*) Collect, evaluate, and disseminate research data and other information related to special equipment, materials, supplies, devices, techniques and training.

(*d*) Provide instruction in the operation or use of equipment, materials, supplies, and devices of the type referred to in item 1 of this enumeration.

(*e*) Provide in-service training for teachers of handicapped persons and other persons requiring special skills or understanding in connection with the education of handicapped persons.

(*f*) Accept, administer, and utilize federal aid and any other grants, gifts, or donations of funds, equipment, materials, supplies, facilities, and services in connection with any of its authorized functions, and comply with any requirements or conditions attached thereto: provided that the same are not inconsistent with law.

Section 602

Availability of Programs

(*a*) The [Unit] shall furnish, lend, or otherwise make available its equipment, materials, supplies, and devices to public school systems, private nonprofit schools, special schools or institutions for handicapped children, and public and private nonprofit institutions of higher learning.

(*b*) Public and private nonprofit institutions and organizations operating programs of vocational rehabilitation [recognized or approved] pursuant to [cite appropriate statute] also shall be eligible in the same manner as institutions qualifying under subsection (a) hereof.

(*c*) Pre-school public and private nonprofit programs for the education of handicapped children also shall be eligible in the same manner as institutions qualifying under subsection (a) hereof, if approved by the [Unit].

(*d*) Handicapped persons may apply for and receive equipment, materials, supplies and devices on an individual basis of the [Unit] has established loan or other services for making the same available to users not covered by subsections (a)–(c) hereof and has provided appropriate procedures therefor.

(*e*) The [Unit] shall make equipment, materials, supplies, or devices available pursuant to subsections (a)–(c) hereof only on written application made in such form and manner as it may prescribe. The application shall be approved, and equipment, materials, supplies, or devices furnished only if the [Unit] is satified that the applicant has a need therefor and is capable of putting them to appropriate use. Applications shall contain information concerning the number of handicapped children for whom the applicant is providing instruction or, in the case of a new institution or program, the number expected to be so served; the type or types of handicap; and such other information as the [Unit] may require.

Section 603

Regional Service

(*a*) Except as may be provided pursuant to this Section, the [Unit] shall provide equipment, materials, supplies, devices and in-service training only to schools and school systems, institutions, organizations, and persons in this state.

(*b*) In view of the specialized character of the functions of the [Unit], it is recognized that its support and utilization on a multistate or regional basis may promote efficiency and economy, and may make it possible for more persons in need of special education to receive it. Accordingly, it is the policy of this state to encourage multistate and regional cooperation to that end.

(*c*) The [State Department of Education] may enter into contracts with other states or their appropriate educational agencies for the furnishing of services, equipment, materials, supplies, or devices by the [Unit]. Such contracts may provide for the carrying on of any one or more functions which the [Unit] is authorized to perform in such manner as to serve schools and school systems, institutions, organizations, and persons in such other state or states: provided that unless the activities covered by the contract are financed entirely by the other state or states, including the maintenance of a separate staff or the pro rata contribution to the salaries and other compensation of staff partly employed for the benefit of one or more other states and this state, no school or school system, institution, organization, or person may be furnished with equipment, materials, supplies, devices, or training who would be ineligible to receive the same under the laws of this state.

(*d*) Contracts made pursuant to this Section shall provide for:

1. their duration;
2. appropriate consideration and the payment thereof;
3. the nature and extent of the equipment, materials, supplies, devices, and training to be furnished and received;
4. the performance of inspections and examinations and the making of reports; the evaluation thereof; and the granting or denial of benefits on the basis thereof;
5. any other necessary and appropriate matters.

(*e*) Consideration provided by any contract made with the [State Department of Education] pursuant to this Section shall be at least sufficient to cover the cost of any equipment, materials, supplies, or devices furnished, and an equitable share of the operating costs in connection with any in-service training given to persons from other states. It shall be a guiding principle for the making of contracts pursuant to this Section that if the use made or to be made of the [Unit] by another state is in excess of [10] per cent of the use made by this state and schools and school systems, institutions, organizations, or persons in this state, consideration required from such other state shall include an equitable contribution to overhead and capital costs, as well as to operating costs and costs of equipment, materials, supplies, and devices furnished.

Section 604

Contracting Authority

The [State Education Agency] is authorized to enter into contracts for the furnishing of equipment, materials, supplies, devices, and personnel training that are peculiarly useful in the teaching of handicapped children. The [State Education Agency] may pay such consideration, out of funds available therefor, as may be appropriate and equitable in the circumstances. If another state, public agency, or private nonprofit agency establishes and maintains a substantial, specialized program for the development, production, procurement, and distribution of special equipment, materials, supplies, and devices, or for the training of personnel useful in the teaching of handicapped children, and if the contract or contracts entered into pursuant to this Section assure this state of substantial benefits therefrom on a continuing basis, consideration paid by the [State Education Agency] may be calculated to include overhead and capital costs as well as more immediately operational costs and the costs of any articles or services furnished or to be furnished.

Section 605

Availability of Articles and Servies

Any articles or services secured by or though the [State Education Agency] pursuant to contracts made under authority of this Title may be made available to any school systems, special schools or other persons and entities entitled to participate in or receive benefits from special services to the handicapped. The ultimate apportionment and bearing of costs as among the state, subdivisions thereof and other persons and entities shall be in accordance with law.

Section 606

Inspections, Reports, and Records

(*a*) The [Unit] may inspect the facilities of any applicant for or recipient if its equipment, materials, supplies, and devices and may examine any pertinent records in order to determine facts relevant to the administration of this Title. For this purpose, the [Unit] and its duly authorized representatives shall have access to the premises and any pertinent records of the applicant or recipient at all reasonable times.

(*b*) The [Unit] may require reasonable reports from any recipient institution or program detailing the uses made of equipment, materials, supplies, and devices made available pursuant to this Title, and of the workability or beneficial effects obtained therefrom.

(c) The [Head of the State Education Agency] may provide for the consolidation of inspections, examinations of records, and making of reports pursuant to this Section with other inspections, examinations, and reports made or required to be made by the [State Education Agency] or may permit them to be separate, as in his judgment is most appropriate to the proper administration of this Title and the promotion of general efficiency.

Section 607

Relationship of the Unit to Other Entities

(*a*) Unless the function is performed for it by a Special Education Services Association each school district and state institution shall establish and maintain a special education resources center which shall perform the functions of procurement, maintenance, servicing and distribution of special education equipment, supplies and materials to the schools of the district and to any other persons or entities to which they are made available pursuant to law. Special education equipment, supplies, and materials made available to schools and other entities shall be provided, made available and inventoried by such center.

(*b*) To the extent of its capabilities, a special education resources center may establish and operate or cooperate with others in establishing and operating programs or in-service training similar to those authorized for the state unit by Part VIII of this Title.

(*c*) Centers established as required by this Section shall cooperate with and may borrow or otherwise obtain from the state unit, regional instructional materials centers, federal and other governmental agencies, and appropriate private agencies such equipment, supplies and materials as may be available therefrom and may be responsible for their proper distribution to and collection from schools and othere entities entitled to receive and utilize them.

(*d*) It is the purpose of this Section to promote the efficient and expert use of special education aids and to discourage their being positioned, kept or made available for use by persons and under conditions not conducive to their proper employment. The Division for the Education of the Handicapped shall develop, revise and keep in force regulations and guidelines for the operation of centers and for their relationships to schools or other proper recipient entities. The state Unit shall assist centers in their programs of training, equipment servicing, distribution and general administration.

(*e*) The state Unit shall encourage the maintenance of centers by Special Education Services Associations on behalf of their participating school districts, except in those instances where an individual school district has qualified as a Special Education Services Association.

PART VII. REMEDIES

Section 700

Administrative and Judicial Review

(*a*) A child, or his parent or guardian, may obtain review of an action or omission by state or local authorities on the ground that the child has been or is about to be:

1. denied entry or continuance in a program of special education appropriate to his condition and needs.
2. placed in a special education program which is inappropriate to his condition and needs.
3. denied educational services because no suitable program of education or related services is maintained.
4. provided with special education or other education which is insufficient in quantity to satify the requirements of law.
5. provided with special education or other education to which he is entitled only by units of government or in situations which are not those having the primary responsibility for providing the services in question.
6. assigned to a program of special education when he is not handicapped.

(*b*) The parent or guardian of a child placed or denied placement in a program of special education shall be notified promptly, by registered certified mail return receipt requested, of such placement, denial or impending placement or denial. Such notice shall contain a statement informing the parent or guardian that he is entitled to review of the determination and of the procedure for obtaining such review.

(*c*) The notice shall contain the information that a hearing may be had, upon written request, no less than [15] days nor more than [30] days from the date on when the notice was received.

(*d*) No change in the program assignment or status of a handicapped child shall be made within the period afforded the parent or guardian to request a hearing, which period shall not be less than [14] days, except that such change may be made with the written consent of the parent or guardian. If the health or safety of the child or of other persons would be endangered by delaying the change in assignment, the change may be sooner made, but without prejudice to any rights that the child and his parent or guardian may have pursuant to this Section or otherwise pursuant to law.

(*e*) The parent or guardian shall have access to any reports, records, clinical evaluations or other materials upon which the determination to be reviewed was wholly or partially based or which could reasonably have a bearing on the correctness of the determination. At any hearing held pursuant to this Section, the child and his parent or guardian shall be entitled to examine and cross examine witnesses, to introduce evidence, to appear in person, and to be represented by counsel. A full record of the hearing shall be made and kept, including a transcript thereof if requested by the parent or guardian.

(*f*) A parent or guardian, if he believes the diagnosis or evaluation of his child as shown in the records made available to him pursuant to subsection (e) to be in error, may request an independent examination and evaluation of the child and shall have the right to secure the same and to have the report thereof presented as evidence in the proceeding. If the parent or guardian is financially unable to afford an independent examination or evaluation, it shall be provided at state expense.

(*g*) The [state education agency] shall make and, from time to time, may amend or revise rules and regulations for the conduct of hearings authorized by this Section and otherwise for the implementation of its purpose. Among other things, such rules and regulations shall require that the hearing officer or board be a person or composed of persons other than those who participated in the action or who are responsible for the omission being complained of; fix the qualifications of the hearing officer or officers; and provide that the hearing officer or board shall have authority to affirm, reverse or modify the action previously taken and to order the taking of appropriate action. The rules and regulations shall govern proceedings pursuant to this Section, whether held by the [state education agency] or by a [local education agency].

(*h*) The determination of a hearing officer or board shall be subject to judicial review [in the manner provided by the state administrative procedure act] [in the manner provided for judicial review of determinations] of the [state or local education agency] as the case may be. [If there is no applicable procedure, appropriate statutory provisions should be added here].

(*i*) If a determination or hearing officer or board is not fully complied with or implemented the aggrieved party may enforce it by a proceeding in the [ ] Court. Any action pursuant to this subsection shall not be a bar to any administrative or judicial proceeding by or at the instance of the [state education agency] to secure compliance or otherwise to secure proper administration of laws and regulations relating to the provision of regular or special education.

(*j*) The remedies provided by this Section are in addition to any other remedies which a child, his parent or guardian may otherwise have pursuant to law.

Section 701

Enforcement Not Affected

Nothing in this Title shall be construed to limit any right which any child or his parent or guardian may have to enforce the provision of any regular or special educational service; nor shall the time at which school districts are required to submit plans or proceed with implementation of special education programs be taken as authorizing any delay in the provision of education or related services to which a child may otherwise be entitled.

Section 702

Direct State Action

(*a*) If, at any time after [,] a school district is found by the [state education agency] to have failed to provide necessary education to all handicapped children who by law are entitled to receive the same from such school district, the [state education agency] may withhold all or such portion of the state aid for the regular public schools as, in its judgement, is warranted. The denial of state aid hereunder may continue until the failure to provide special education university. Such traineeships and fellowships may be in amounts of not more than [$] per academic year for traineeships and not more than [$] per academic year for fellowships with [$] per year legal dependent except in addition, an additional sum up to [$] annually for each grantee may be allowed to any approved institution of higher learning in this state for the actual cost to the institution, as certified by the institution. Part-time students and summer session students may be awarded grants on a prorata basis.

(*b*) The Division for the Education of the Handicapped may contract with any approved institution of higher learning to offer courses required for the training of special education personnel at such times and locations as may best serve the needs of handicapped children in this state.

(*c*) The Division for the Education of the Handicapped shall administer traineeship and fellowship accounts and related records of each person who is attending an institution of higher learning under a traineeship or fellowship awarded pursuant to this Section.

(*d*) Following the completion of the program of study, the recipient of a traineeship or fellowship is expected to accept employment within one year in an approved program of education for handicapped children in this state on the basis of one-half year of service for each academic year of training received through a grant made under this Section. A person who fails to comply with this provision may, at the discretion of the Division for the Education of the Handicapped be required to refund all or part of traineeship or fellowship monies received.

Section 803

Grants

The Division may provide grants to public and private agencies for such research, development, and model programs as are required to promote effective special education.

PART IX. FACILITIES

Section 900

Regular School Facilities

(a) Every school district of this state constructing, renovating, remodeling, expanding or modifying school buildings or other structures intended as adjuncts thereto shall plan, design, construct and equip all such buildings and structures in such manner and with such materials as will facilitate use by all handicapped children who may reasonably be expected to enter upon the premises and to make use of them for instructional, remedial or supplementary services. This Section shall be interpreted and administered in the light of the policy of this state to educate and provide services for handicapped children in or in close proximity to the regular schools to the maximum practicable extent.

(*b*) No school or school-related construction, renovation, remodeling, expansion or modification shall be eligible for state aid pursuant to [cite appropriate statute] unless the [state education agency] finds that it is in conformity with subsection (a) hereof and [title of state law prohibiting architectural barriers for the handicapped].

Section 901

Plans and Specifications

(*a*) Plans and specifications for every special education facility shall be prepared in two parts, as follows:

1. A statement of the educational and related objectives and functions to be served and the uses to be made of the facility.
2. Architectural plans and specifications.

(*b*) Plans as required by subsection (a) hereof shall be submitted to the [state education agency] for approval thereby. Such approval shall be a prerequisite to the awarding of any construction contract in connection with the facility, except for contracts for the development of the plans and specifications required to be submitted: nor shall any construction commence or perimt therefor be issued prior to approval of the plans and specifications by the [state education agency].

(*c*) Approval shall be given only if the Division of Education for the Handicapped determines that the architectural plans and specifications properly implement the stated educational and related objectives and functions, and if the [state school construction agency] determines that the architectural plans and specifications provide for design, materials and equipment appropriate to serve the stated objectives and functions. If the submission is of plans and specifications for a building or other structure which does not include a special education facility, approval by the Division of Education for the Handicapped shall be limited to a certification that the submitting authority has other facilities adequate to meet the needs of handicapped children.

(*d*) No facility to which this Section applies shall be accepted by any agency of this state, or any school district, [Special Education Services Associations], or subdivision unless it conforms to the plans and specifications as approved, or as amended pursuant to subsection (e) hereof.

(*e*) Subsequent to approval of plans and specifications pursuant to this Section, they may be amended on a showing that the stated educational and related objectives and functions have been replaced by other suitable objectives and functions and that the architectural plans and specifications have been modified to conform to the new objectives and functions, or that the proposed amendment of architectural plans and specifications will not impair the suitability of the facility for the previously stated objectives and functions. Amendments shall be submitted and approved in the same manner as original submissions.

(*f*) Any entity which may be eligible for state aid pursuant to [cite statute providing state aid to construction of special education facilities], may qualify therefor only on submission and approval of plans and specifications in accordance with this Part.

Section 902.

RULES, REGULATIONS AND MANUAL

(*a*) The [state education agency] shall issue, and from time to time amend and revise, rules and regulations for the implementation of this Part. Such rules and regulations shall include procedures for submission and review of plans and specifications and may include requirements for additional information to be furnished by school districts, Sepcial Education Services Associations, or entities constructing or proposing to construct special education facilities.

(*b*) The [state education agency] shall develop and publish a manual containing educational, and architectural standards to be met by special education facilities. The manual shall be incorporated in the rules and regulations issued pursuant to this Part and no approval or acceptance of a facility shall be lawful, except on compliance with the standards contained herein.

(*c*) The manual shall be developed, amended, and revised with due regard for standards applicable to the construction of special education facilities issued by recognized professional organizations.

(*d*) Public and private builders and operators of special education facilities may consult with the [state education agency] concerning any matter related to the administration of this Part or any special education facility proposed to be constructed or operated by them, but no such consultation and no representation made shall be construed as an approval of plans and specifications. Such approval may be given only purusant to Section 901 of this Act.

PART X. FINANCE

Section 1000.

State Aid to be Provided

The state shall provide financial aid in each school year to school districts and other [public entities] [entities entitled by the laws of this state to receive school aid] for educational and related services provided by them for handicapped children. Such aid shall be determined and paid in accordance with this Part and rules and regulations of the [state education agency].

Section 1001

Elements to be Aided

State financial aid pursuant to this Title may be claimed by and shall be paid to any public school district or other [public entity] [entities entitled by the laws of this state to receive school aid] for each of the following elements:

(*a*) The education of handicapped children in the regular school programs of the district or entity.

(*b*) The education of handicapped children in special classes, schools and programs designed to meet their special needs; and the furnishing of corrective or remedial services designed to ameliorate or eliminate physical, mental, emotional, or learning disabilities or handicaps.

(*c*) The furnishing of transporatation.

Section 1002

Amounts of Aid

(*a*) For purposes of entitlement to state aid, handicapped children shall be counted in the same manner as other children. [Per pupil aid shall be determined on the same basis as for normal children pursuant to [[cite appropriate section of state law]].] [Units shall be allotted for handicapped children in accordance with [[cite appropriate provision of Minimum Foundation Program Laws]], except that allowance of any lesser number of pupils to comprise a standard or minimum unit shall continue as provided in [[cite appropriate section of state law]].]

(*b*) In addition to the state aid claimed and paid pursuant to subsection (a) hereof, any school district or Special Education Services Association which has maintained an approved program of education for handicapped children during any school year shall be entitled to and receive reimbursement from the state for the excess cost of the individuals in said program above the cost of pupils in the regular curriculum which shall be determined in the following manner:

1. Each district shall keep an accurate, detailed, and separate account of all money's paid out by it for the maintenance of each of the types of classes and schools for the instruction and care of pupils attending them and for the cost of their transportation, and shall annually report thereon, indicating the excess cost for elementary or high school pupils for the school year ending [ ] over the last ascertained average cost for the instruction of regular children in the elementary public schools or public high schools as the case might be, of the school district for a like period of time of attendance.

2. Each Special Education Services Association shall keep an accurate, detailed, and separate account of all monies paid out by it for the maintenance of each of the types of classes and schools for the instruction and care of pupils attending them and for the cost of their transportation, and shall annually report thereon, indicating the excess cost for elementary or high school pupils for the school year ending in [ ] over the last ascertained average cost for the instruction of regular children in the elementary public schools or public high schools as the case might be, of the school districts served by the Special Education Services Association for a like period of attendance.

(c) [In addition to any state aid for the transportation of children to and from school and other transportation in connection with school-related activities], the [state education agency], upon a claim properly substantiated, shall pay 100 percent of the costs of special buses and other special equipment actually employed in transporting handicapped children.

Section 1003

Apportionment of Aid

If any of the educational or other services aided pursuant to this Part are provided partly by one school district or other entitled entity and partly by another such district or entity, and if there is no valid contract or agreement by which one of the districts or entities is the proper claimant for all the aid in question, each such district and entity shall be entitled to claim and receive a proportionate share of State aid in accordance with its actual assumption of costs. The [state education agency] shall provide for the calculation and apportionment of state aid in cases covered by this subsection.

Section 1004

Special Fund

(a) There is hereby established a Special Education Fund in the state treasury. Each budget of the [state education agency] shall contain an appropriation item for the Fund. It is the legislative intent that the Fund shall be kept at a level that will permit an annual rate of expenditure therefrom of not less than [$].

(*b*) The [state education agency] shall make grants from the Fund to school districts, special education services associations, and other appropriate entities. The purposes of such grants shall be to make it possible for the recipients to: 1. secure technical assistance with planning, design, acquisition, and construction of facilities or equipment for the education of handicapped children. 2. Supplement otherwise available but inadequate funds for planning, design, acquisitions, or construction of facilities or equipment for the education of handicapped children.

(*c*) In applying for grants under this Section, a school district, special education services association, or other appropriate entities shall demonstrate that it proposes to use the aid for a purpose identified in the state plan made pursuant to Section [   ] of this title as requiring particular current attention or for a purpose selected by the division of education for the handicapped as one currently to receive concentrated efforts at improvement.

(*d*) Grants pursuant to this Section shall be in addition to regular or sp3cial aid otherwise available from the state for educational purposes.

Section 1005

Federal Aid

The [state education agency] may apply for, administer, receive, and expend any federal aid for which this state may be eligible in the administration of this Title. If such aid is available for a multistate or regional program in which this state participates pursuant to one or more contracts in force pursuant to this Title, the [state education agency] may apply for and devote all or a portion of the federal aid to the multistate or regional program.

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District of Columbia Department of Special Education Tuition Grant Program 1970–1971

1970–71

Area of disability and private school	Type of school	Location of school	Number of District of Columbia pupils on grants	Private school's per pupil cost	Average cost per area of handicap
Blind:					
Maryland	Residential	Maryland	19	$5,400	$4,931
Perkins	do	Massachusetts	1	7,000	
Pilot	Day	District	10	3,000	
Deaf:					
Kendall	do	do	128	1,790	1,787
St. Joseph's	Residential	Missouri	1	2,700	
Emotionally disturbed:					
Cardigan Mountain	do	New Hampshire	1	3,500	3,452
Christ Child	do	Maryland	2	3,043	
Contemporary	Day	Virginia	17	4,620	
Devereux	Residential	Pennsylvania	3	12,000	
Eberhard	Day	District	3	1,650	
Foster	Residential	New Jersey	1	4,200	
Glaydin	do	Virginia	4	2,625	
Green Chimneys	do	New York	4	5,675	
Greig	Day	District	18	4,184	
Hillcrest	Day/residential	do	17	9,000/16,000	
Lourdesmont	Residential	Pennsylvania	1	6,023	
McLaren	do	New York	1	4,800	
New Jersey	do	New Jersey	1	7,500	
Overbrook	Day/residential	Virginia	2	3,000/8,000	
Hearing impaired:					
Childrens	Day	District	12	3,000	2,653
Gallaudet	do	do	1	876	
Washington	do	do	15	2,566	
Mentally retarded:					
Angels Haven	Residential	Maryland	1	4,200	1,684
Benedictine	do	do	2	2,000	
Christ Church	Day	do	3	2,222	
Holly Hall	Residential	Virginia	1	1,350	
Help For Retarded	Day	District	20	1,000	
Kennedy	do	do	33	1,000	
National	Day/residential	do	25	2,619	
St. Gertrude's	do	do	8	1,350/540	
St. John's	Day	do	41	2,000	
St. Maurice	do	Maryland	13	1,580	
Multiple and health:					
Cooperative	do	Virginia	8	1,420	1,343
D.C. Society	do	District	25	600	
Matheny	Residential	New Jersey	1	9,600	
National Rehabilitation	do	Virginia	2	10,500	
Neurological:					
Grafton	do	do	1	6,050	2,792
Green Hedges	Day	do	1	1,100	
Hopefield	Residential	Massachusetts	1	4,000	
Kingsbury	Day	District	15	3,100	
Leary	do	Virginia	7	2,800	
New City	do	District	1	1,225	
Pine Point	Residential	Maine	1	4,000	
Schefer	Day	Virginia	1	1,150	
Vanguard	Residential	Pennsylvania	1	6,500	

Note: 7 areas; 45 schools; day, 20; residential, 21; both, 4; 10 localities; total number of pupils, 484; 4 cases in process; tuition grants determined according to June 17, 1970, board policy.

Source: Department of Special Education, Tuition Grant Program.

Directory of Non-Public Facilities by the Special Education Tuition Grant Office, Public Schools of the District of Columbia

Angel's Haven, Inc., Rte. #2, Box 548, Glen Burnie, Md. 21061. 301/761–1588. Director: Grace Spiro. Type of Child Served: Mentally Retarded. Ages: 3–15.

Benedictine School, Caroline County, Ridgely, Md. 21660. 301/634–2112. Director: Sister Miriam Thomas. Type of Child Served: Educable Mentally Handicapped. Ages: 5–15.

Berkshire Learning Institute, Reservoir Road, Lenox, Massachusetts 01240. 413/637–3635. Director: Matthew J. Merritt. Type of Child Served: Learning Disabilities. Ages: 12–20.

Brookside School, Great Barrington, Massachusetts 01230. 413/528–0570. Director: Dr. I. M. Altaraz. Type of Child Served: Underachievers, Emotional. Ages: 10–15.

Cardigan Mountain School, Canaan, New Hampshire 03741. 603/523–4321. Director: Norman C. Wakely. Type of Child Served: Emotionally Disturbed, Socially Maladjusted. Ages: 12–16.

Children's Hearing and Speech Center, 2220–11th Street, N.W., Washington, D.C. 20001. 234–7990. Director: Dr. Gilbert Herer. Type of Child Served: Hearing Impairment, Speech Disorders. Ages: Birth–12 Years.

Christ Child Institute, Edson Lane, Rockville, Md. 20852. 301/881–5777. Director: Kenneth R. Crites Type of Child Served: Emotionally Disturbed Ages: Boys: 4½–8½, Girls: 4½–10½.

Christ Church Child Center, 8011 Old Georgetown Road, Bethesda, Md. 20014. 301/652–3922. Director: Shari Gelman. Type of Child Served: Mentally Retarded, Learning Disabilities, Emotional. Ages: 4–10.

D.C. Society for Crippled Children, 2800–13th Street, N.W., Washington, D.C. 20009. AD 2–2342. Director: William J. Fidler. Type of Child Served: Cerebral Palsied, Brain Damaged, Mongolism, Multiple. Ages: 2–7.

Devereux Foundation, Devon, Pennsylvania 19333. 687–3000. Director: Marshall H. Jarvis. Type of Child Served: Retarded, Emotionally Disturbed. Ages: 4–18.

Eberhard School, 7750 16th Street, N.W., Washington, D.C. 20012. 829–0088. Director: Leon E. Eberhard. Type of Child Served: Underachievers, Emotional. Ages: 14–18.

Glaydin School and Camp, Rte. *4, Box 143, Leesburg, Virginia 22075. 703/777–3505. Director: Jane G. Wilhelm. Type of Child Served: Emotional and Academic Underachievers. Ages: 9–17.

Green Chimneys School, R.D. *3, Brewster, New York 10509. 914/279–2996. Director: Samuel B. Ross. Type of Child Served: Emotional, Neurological. Ages: 4–14.

Green River Academy, Rte. *71, North Egremont, Massachusetts 01252. 528–4546. Director: Nan G. Portass. Type of Child Served: Emotionally Disturbed, Socially Maladjusted. Ages: 13–18.

Agnes Bruce Greig School, 5450 Massachusetts Avenue, N.W., Washington, D.C. 20016. 244–8806. Director: Mildred E. Berl, Type of Child Served: Neurological. Ages: 5–14.

Help for Retarded Children, Inc., 405 Riggs Road, N.E., Washington, D.C. 20011. 529–0070. Director: Dr. David Silberman. Type of Child Served: Mentally Retarded, Emotionally Disturbed, Epileptic. Ages: 13–Up.

Hillcrest Children's Center, 1325 W Street, N.W., Washington, D.C. 20009. 265–2400. Director: Rose Alpher. Type of Child Served: Emotionally Disturbed. Ages: 3–12.

Holly Hall School, Inc., 437 Knoll Street, N.W., Vienna, Virginia 22180. 703/938–7040. Director: Esther C. Thomas. Type of Child Served: Mentally Retarded, Physically Handicapped. Ages: All.

Lt. Joseph Kennedy Institute, 801 Buchanan Street, N.E., Washington, D.C. 20017. 529–3515. Director: Sister Mary Reilly. Type of Child Served: Educable Mentally Retarded, Emotional. Ages: 6–18.

Kingsbury Center, 1809 Phelps Place, N.W., Washington, D.C. 20008. 232–5878. Director: Sally L. Smith, Type of Child Served: Neurological, Specific Learning Disabilities. Ages: 6–12.

Leary School & Educational Center, 2849 Meadow View Road, Falls Church, Virginia 22042. 703/573-5400. Director: Albert D. Leary. Type of Child Served: Underachievers, Learning Disabilities, Emotional. Ages: 7-18.

Lourdesmont School, 537 Venard Road, Clarks Summit, Pennsylvania 18411. 717/586-2971. Director: Sister M. Angela. Type of Child Served: Mildly Emotionally Disturbed, Socially Maladjusted. Ages: 14-17.

McLean School, 10401 Democracy Lane, Potomac, Md. 20854. 365-5900. Director: Mr. Byrnes. Type of Child Served: Multiple Learning Disabilities. Ages: 8-14.

Maryland School F/T Blind, 3501 Taylor Avenue, Baltimore, Md. 21236. 301/444-5000. Director: Herbert J. Wolfe. Type of Child Served: Visually Impaired. Ages: 5-21.

Matheny School, Main Street, Peapack, New Jersey 07977. 201/234-0011. Director: Walter D. Matheny. Type of Child Served: Cerebral Palsied. Ages: 5-15.

National Children's Center, 6200-2nd Street, N.W., Washington, D.C. 20011. 726-1090. Director: Dr. Erwin Friedman. Type of Child Served: Mentally Retarded. Ages: 6-16, 3-6.

National Children's Center, Pilot School Unit, 6200-2nd Street, N.W., Washington, D.C. 20011. 726-1090. Director: Robert C. Heaton. Type of Child Served: Visually Impaired, Multiple Handicapped. Ages: 3-16.

National Children's Rehab. Center, P.O. Box 1260, Leesburg, Virginia 22075. 703/777-3485. Director: Bernard Haberlein. Type of Child Served: Epeliptic, Emotionally Distrubed. Ages: 7-17.

New City Montessori School, 2421 Lawrence Street, N.E., Washington, D.C. 20018. 526-3331. Director: Walter Hardesty. Type of Child Served: Learning Disabilities. Ages: 2½-11.

New Jersey Youth Center for Boys, P.O. Box 606, Millville, New Jersey 08332. 609/825-7474. Director: McCaigher Gallagher. Type of Child Served: Emotionally Distured, Socially Maladjusted. Ages: 8-18.

Perkins School F/T Blind, 175 N. Beacon Street, Watertown, Massachusetts 02172. 617/925-3434. Director: Dr. E. J. Waterhouse. Type of Child Served: Blind, Deaf-Blind, Blind-Cerebral Palsy. Ages: 5-17.

Pine Point School, Camden, Maine 04843. 207/236-2619. Director: Donald Zambri. Type of Child Served: Slow Learners, Mild Mental Retardation. Ages: 7-15.

Riverview School, Inc., Rte. #6A, East Sandwich, Massachusetts 02537. 617/888-0489. Director: C. W. Mores. Type of Child Served: Brain Damaged, Underachievers. Ages: 13-18.

School for Contemporary Education, 1530 Chain Bridge Road, McLean, Virginia 22101. 356-8870. Director: Dr. E. Lakin Phillips. Type of Child Served: Emotionally Distrubed, Retarded, Learning Disabilities. Ages: 4-20.

St. Gertrude's School, 4801 Sargent Road, N.E., Washington, D.C. 20017. 526-7676. Director: Sister Maureen. Type of Child Served: Educable Mentally Retarded, Moderately Emotionally Disturbed. Ages: 6-12.

St. Joseph's Institute F/T Deaf, 1483 82nd Boulevard, St. Louis, Missouri 63132. 314/993-1507. Director: Sister Jean Timothy. Type of Child Served: Deaf Ages: 4-15.

St. John's Child Development Center, 5005 MacArthur Boulevard, N.W., Washington, D.C. 20016. 363-7032. Director: Dr. Maurice Fouracre. Type of Child Served: Mentally Retarded. Ages: 3-18.

St. Maurice Day School, 10100 Kentsdale Drive, Potomac, Md. 20854. 301/299-7303. Director; Sister Monica Marie. Type of Child Served: Learning Disabilities. Ages: 5-18.

Washington Hearing Society, 1934 Calvert Street, N.W., Washington, D.C. 2009. 265-7335. Director: Leonard Henley. Type of Child Served: Deaf, Hard of Hearing, Speech Disorders. Ages: 2-6.

21st Century Learning Centers, Plus, 900 Eye Street, S.W., Washington, D.C. 554-4330. Director: Dr. J. Beverly Fellows. Type of Child Served: Emotional, Learning Disabilities, Retardation. Ages: 6-21.

Dr. John L. Johnson, Associate Superintendent, Tuition Grant Officer.

Chronology of Some of the Efforts of Concerned Citizens for Exceptional Children of the District of Columbia, 813 C Street, S.E., Washington, D.C. 20003

CONCERNED CITIZENS FOR EXCEPTIONAL CHILDREN OF THE DISTRICT OF COLUMBIA—STATEMENT OF SANDRA B. FROMM, HEARINGS, SUBCOMMITTEE ON DISTRICT OF COLUMBIA APPROPRIATIONS, U.S. HOUSE OF REPRESENTATIVES, JULY 20, 1971

We appreciate this opportunity to present to this Subcommittee our plea for a budgetary allocation for Special Education that will at least *begin* to be responsive to the enormous, indeed, tragic unmet needs of literally thousands of handicapped children in this city, and that will add strength to its school system as a whole.

The attached data which, with your permission, we would like to have made part of the record of these hearings, indicates beyond dispute, the shocking gap between the needs of the handicapped—both estimated and documented—and the meagre services provided.

In a city such as ours, incidence rates indicate that over 20,000 school age children are likely to be afflicted with some handicap. It can only be termed appalling that fewer than 2,000 are being served by the Department of Special Education and Tuition Grants, and a small percentage of the remainder receive limited supportive services through the regular instruction program. Despite meagre diagnostic facilities, well over 1,000 children are on various *formal* waiting lists, and *thousands more* are in need of special attention.

For years, studies of the D.C. schools have urged comprehensive "crash programs" to meet the needs of the handicapped. For years, funding for Special Education has remained pitifully inadequate. The city has many pressing and unmet needs, and so, because of "priorities," "budgetary constraints," "fiscal responsibility," innocent children and their families—and, ultimately, our society—suffer tremendous waste, both human and economic.

Repeated surveys place the cost of a 12-year educational program for a handicapped child at between $20,000 and $30,000. Costs of life-time institutional care are estimated at $200,000. I call to your attention a statement in the *Congressional Record*, April 14, 1971:

"* * * helping the handicapped is a social and economic necessity * * * [a] $30,000 investment in education can lead to a potential wage-earning for a handicapped individual of close to $300,000 during a lifetime of productive work. The tax from this income alone would repay the cost of the education."

As you know, there has been increasing Federal and State support of programs for the handicapped. Each of your own home towns, usually with considerable state assistance, attempts to cope with the problem of educating its handicapped. If you will compare numbers served, proportionately, I think you will gain added perspective on how desperately increased support is needed for the children in The Nation's Capital.

Although one may be genuinely sympathetic to the circumstances, it is difficult, if not impossible, for anyone whose life has not been touched by the tragedy of having a handicapped child to understand fully the further deprivation—the lack of opportunity for appropriate education—that the handicapped child suffers. As you fully realize, handicapping conditions affect children at all levels of society throughout the nation. There are members of the Congress who confront the problem in their own families. They seek for their children, in their home communities and in the Washington area, the kind of education that will afford them the best chance to achieve their potential and, hopefully, to become productive, self-supporting adults. We seek this opportunity for all handicapped children, including those in the District of Columbia. We look to you to *begin* to make it possible in FY 72.

I wish that you could talk to the parents of some of these children—to hear of their long, unsuccessful struggles to place a child in a special class or a special school, to listen to their fears for the future of a child in a regular 6th grade class who has yet to learn the alphabet, who is taunted, frustrated, destined to become a drop-out (and then what?)—or to share for one day the despair of a family with a child so profoundly disabled or so severely disruptive that the has been excluded completely from the D.C. school system. Even more, I wish you could have heard, as I did a few months ago, the first meaningful word of an aphasic boy of 6, of normal intellect, but with a brain injury that had impaired his ability to speak. Appropriate techniques and devoted teaching have made it possible for him now to have a different, far happier prospect for the future. I had never imagined that "Hi" could sound so important.

This Subcommittee has long given gracious, sympathetic hearing to testimony by citizen groups.

We are not unmindful of the complex problems involved in the D.C. budget decisions you must make. But we ask you to keep in mind that inadequate appropriations will continue to deprive handicapped children of an education. This is, in our view, totally unconscionable—unless one can repudiate the Constitutional right of *all* children to an education.

We ask you to share in a commitment to the handicapped—and to support feeling with appropriations that will make some progress toward rectifying the tremendous discrepancy between requirements and actual services provided. We ask you to share the deep concern shown by the counterpart Senate Subcommittee, which, after hearing outside witnesses, recalled the school authorities in order to determine the minimum funds required to serve, at least, the current waiting lists. Given the data, no reasonable person can be convinced that the proposed $6.9 million for Special Education can possibly come close to satisfying even these demonstrated needs—despite stringent economy and elimination of all non-essentials.

We urgently request your careful consideration of a figure close to the level of the "Minimal Needs Budget" originally proposed by the Board of Education and an appropriation of $10.6 million ($8.3 million for Special Education programs and $2.3 million for tution grants). Supporting data is attached. I shall gladly discuss any of its specific details if you wish.

Your failure to provide this amount will force too many children to wait still another precious year, and to lose an irretrievable part of their already limited chance to salvage their lives.

INCREASED SERVICES THAT WOULD BE MADE POSSIBLE BY A 1972 ALLOCATION OF $8.3 MILLION TO SPECIAL EDUCATION PROGRAMS AND $2.3 MILLION FOR TUITION AID (TOTAL $10.6 MILLION)

1. 24 new learning-disability classes (to provide waiting list children of "normal intellectual potential" an opportunity to achieve their potential).
2. 50 additional teachers for the organically mentally retarded (to satisfy the waiting list and a small number of newly-identified pupils in order to provide for them the possibility of achieving some degree of self-sufficiency).
3. 1 additional teacher for the hearing impaired (to eliminate the waiting list).
4. 5 pre-kindergarten classes (to begin, modestly, an urgently needed program for children identified as handicapped early in life).
5. An additional 50 aides (to enable more productive utilization of teachers' time in special classes which are above the 8:1 pupil-teacher ratio, and to include one aide per class at the new Mamie D. Lee School).
6. 40 teachers for the emotionally disturbed (to permit *some* of the children with behavior problems to receive necessary attention and, as a positive by-product to lessen disruptive situations that plague regular classrooms).
7. 30 additional crisis-resource teachers (to provide the necessary support for children with temporary problems, before the specific problem becomes overwhelming and permanently affects their learning ability).
8. 60 additional diagnostic-prescriptive teachers (to program individual learning exercises for children with learning difficulties who can be served within the framework of regular classes).
9. Basic minimum funds for necessary materials and equipment.
10. Tuition grants for all of the children who have already been declared eligible for placement in private facilities because a program adequate for their special needs is not available in the public schools (an appropriation of $2.3 million would barely provide for current grantees and the waiting list and would not provide for anticipated newly-identified pupils in this category).

GENERAL COMMENTS

1. Limited screening and diagnostic procedures make it impossible to determine accurate statistics for the occurence of handicapping conditions among D.C. pupils.

However, the enormity of the gap between numbers served and probable incidence is obvious (see Table 1).

2. Increased resources for diagnosis, evaluation and periodic reassessment are essential.

3. Appropriate programs must be made available to children identified as suspected of having handicaps.

4. Adequate provision must be made for the sizable number of educable mentally retarded who have been deprived of special classes as a result of misinterpretation of the Wright decision.

5. Expanded vocational training is necessary in order to enable the handicapped to become productive and avoid long-term cost to society.

6. Disabilities are more readily ameliorated by early remediation and treatment. Pre-school programs for the handicapped must be instituted.

7. To fulfill the needs of the current waiting list would provide for less than 10% of the children in need of special services (1,783 of 19,837 children—see Tables 1 and 2).

8. Funds are needed to provide tuition grants for instruction in pirvate institutions when adequate programs are not available in the public schools (see Tables 3 and 4).

9. A comprehensive plan for special education should be devised, funded, and implemented so that handicapped children can realize and enjoy their potential and become useful members of society.

TABLE 1.—ESTIMATED INCIDENCE OF SCHOOL-AGE HANDICAPPED CHILDREN IN THE DISTRICT OF COLUMBIA AND NUMBERS ACTUALLY SERVED: SCHOOL YEAR 1970–71—AS OF APRIL 1971

HEW STATISTICS ON THE INCIDENCE OF HANDICAPPING CONDITIONS IN INNER CITY AREAS AS COMPARED TO NUMBERS OF CHILDREN SERVED BY THE DISTRICT OF COLUMBIA SCHOOL SYSTEM

	HEW incidence rate	Served	Estimated unserved
Mentally retarded (7 percent):			
Educable	9,000	(1)	[2] 9,000
Trainable	1,500	625	675
Speech handicapped (3.5 percent)	5,355	(1)	[2] 5,355
Emotionally distrubed (2 percent)	3,060	82	2,534
Special education program "Socially Maladjusted"		[3] 444	
Learning disability (1 percent)	1,533	87	1,446
Hearing impaired and deaf (0.575 percent)	778	40	736
Crippled or health impaired (0.5 percent)	767	211	556
Visually handicapped (0.1 percent)	153	31	121
Total estimate (total incidence 14.675 percent)	22,146	2,309	[2] 19,837
Served by Department of Special Education		[3] 1,200	
Nonpublic resources and tuition grants		665	
Socially maladjusted [4]		444	

[1] None in special education.

[2] Minimal supportive services for a small portion through regular instructional program.

[3] Includes 124 children in developmental center pilot programs; detail above totals 1,076 children.

[4] Served in regular instruction program.

Source of Information on numbers served: Office of Director of Special Education.

TABLE 2.—*Waiting lists of handicapped children in the District of Columbia; school year: 1970–71 (as of May 1, 1971)*

Waiting List for Placement in Special Classes—	
Trainable Mentally Retarded	467
Children with Learning Disabilities	189
Emotionally Disturbed or "Socially Maladjusted"	(1)
Hearing Impaired	8
Visually Impaired	1
Health Impaired	1
Waiting List for Tuition Grants—Various Handicapping Conditions	427

[1] No formal waiting list is kept, since there are no classes designated for the emotionally disturbed. Minimum estimates of children in need are placed between 700 and 2,000. 40 are on the waiting list for Boys-Junior Senior High.

These children have all been diagnosed and evaluated. School authorities have determined that they require special education. Yet, the Alternative 1 Budget submitted by the School Board ($7,033,500 for special education) does not fully satisfy these acknowledged needs. The proposed D.C. Council budget now under consideration provides even less support.

An additional 57 children identified as severely or profoundly retarded (and perhaps twice that number who are unknown to agencies and school authorities) are provided with no appropriate training program.

TABLE 3.—*Statement in special education information bulletin: 1970–71* [1]

Tuition Grants

Funds are provided for tuition grants for instruction in private institutions when an adequate program is not available in the public schools. Tuition grants *are provided for all* [2] severely handicapped children whose needs cannot be met in the public schools. (See Board of Education policy statement for June 17, 1970.)

Medical and psychological examinations required

Documented, definitive information required

Pupils ages 2 through 21

Grant not to exceed $4,000 per year, unless additional amount permitted by Appeals Committee.

Membership:

521 pupils are receiving tuition—

Blind	40
Deaf	192
Emotionally disturbed	79
Health impaired	10
Mentally retarded	138
Multiply-handicapped	32
Neurologically impaired	30

These pupils are enrolled in 36 private schools.

This statement, unfortunately, is highly misleading. The total allocation for tuition grants for FY 1971, $1,205,000, had been assigned prior to the opening of school in September. Approved applications for tuition aid for 427 children have been placed in a "waiting list" category due to lack of funds (see Table 4). The Department of Special Education has discouraged additional applications because it is unable to provide support.

As of May 1, 1971, 465 pupils were actually receiving tuition aid; an additional 15 cases were pending, 25 more, in process.

TABLE 4.—"WAITING LIST" CHILDREN CERTIFIED AS ELIGIBLE FOR TUITION GRANTS, SCHOOL YEAR 1970–71

	As of Nov. 18, 1970	As of May 1, 1971
Total	336	427
Blind	1	1
Deaf	4	4
Emotionally disturbed	124	127
Health impaired	5	(1)
Hearing impaired	4	5
Mentally retarded	103	134
Multiply handicapped	5	15
Neurologically impaired	90	96

[1] Health impaired included in multiply handicapped.

Source: Mrs. Mamie Lindo, Supervising Director, Department of Special Education, District of Columbia Public Schools.

By early December 1970, an additional 6 children had been added to the waiting list, making a total of 342. At that time, according to Mrs. Lindo's estimates, approximately 200 of these children were in the public schools, inappropriately placed; an estimated 100 were in private schools, with their parents paying the total costs and not even being reimbursed for the system's average per pupil expenditure for normal children. The remainder, 30 to 40 children, were at home receiving no school experience. Those in the last group are excluded from school because of profound disability or severely disruptive behavior.

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[1] Page 13.

[2] Emphasis added.

As of May 1, 1971, the waiting list had increased to 427 children. Fifteen cases were reported as pending, and an additional 25 in process. Thus, at a minimum, there are 932 children currently eligible for tuition grants of whom only 465 receive aid. While the number of children requiring assistance is increasing, the anticipated support is decreasing. A recent report from the Department of Special Education projects that only a total of 484 children will be funded by tuition grants during the 1971–72 school year. The estimates given are as follows:

	Number	Estimated per pupil cost
Blind	30	$4,931
Deaf	129	1,787
Emotional disturbed	87	3,452
Hearing impaired	29	2,653
Mentally retarded	141	1,684
Multiply handicapped and health impaired	38	1,343
Neurologically impaired	30	2,792

Because of anticipated increases in tuition charges by private schools, tuition grants to the above group are expected to exhaust the proposed allocation of $1,300,000. An additional $1 million is required to satisfy the present waiting list (that is, approximately 400 grants at an average cost of $2,500). *This still would not provide for newly identified* handicapped children whose needs cannot be met by programs in the public schools.

Statement of Concerned Citizens for Exceptional Children

(Prepared for Hearings on the District of Columbia Budget, U.S. Senate District Committee, April 1971)

Concerned Citizens for Exceptional Children is an umbrella group composed of 35 organizations which embrace the interests of all handicapped chilrden in the District of Columbia. We appreciate this opportunity to present to the Subcommittee our plea for a budgetary allocation that will at least *begin* to be responsive to the enrmous, indeed, tragic, unmet needs of literally thousands of handicapped children in this city, and that will add strength to its school system as a whole.

A quick glance at the data attached to this statement points up the shocking gap between needs—both estimated and documented—and actual services provided. Past allocations of funds have not only been pitifully inadequate to serve the estimated numbers of handicapped children (based on national incidence rates of various handicapping conditions), but they have ignored the education of hundreds of handicapped children already duly identified. During the current school year, almost 1100 children are on waiting lists—467 for placement in classes for the trainable mentally retarded, 189 for special classes for Children with Learning Disabilities, and 398 with various handicapping conditions—for tuition grants to private facilities unmatched in the school system. The Alternative I ("Hold-the-Line") budget submitted by the D.C. Board of Education for Special Education ($8,139,000) barely would fulfill these demonstrated needs. The $5,721,000 special education budget approved by the D.C. City Council fails to make provision for undeniable requirements, and will continue to deprive handicapped children of appropriate education. In our view, this is unconscionable—unless one can repudiate the constitutional right of *all* children to an education.

Moreover, the waiting lists of handicapped children who would be helped by an increased budget are a very small part of the true picture of current deficiencies. HEW statistics on the incidence of handicapped conditions among inner city children place the figure at just under 15% of the total school population. Thus, there may be approximately 22,000 handicapped school-age children in the District of Columbia. The Department of Special Education reports that it has only 1,200 pupils in special classes. An additional 521 receive tuition grants to private facilities, 444 socially maladjusted youngsters are served in the regular instruction program, 154 others are served by other community resources (Total: 2309). Almost 20,000 children remain. Some of these are aided, in varying degrees, by supportive services, but most are simply not receiving any real opportunity to achieve their potential.

I should like to share with you some figures that were obtained from neighboring school systems. Please keep in mind as you consider them that the expected incidence of disability is significantly lower in suburban communities. Over 12,000 pupils are served by Special Education in Prince Georges County—a system of comparable size in student population (153,000). In another neighboring county of significantly smaller population, 6,000 children receive special education at a per pupil expenditure in excess of $3,500. The inadequacies of Special Education in D.C., in terms of numbers of pupils and per-pupil outlays, are of such magnitude that they cannot be disputed.

Because we are not unmindful of the financial problems of this city, were cognize that the appropriate level of funding, which could require a five-fold increase in the Special Education Budget, may be an unrealistic goal. At the same time, we are certain that the District of Columbia must begin to close the appalling gap between the needs of the handicapped and the meager programs currently provided.

A significant start could be achieved by a fiscal year 72 appropriation of $8,297,000 for Special Education. This would enable: 1) 24 new learning-disability classes (to provide handicapped waiting list children "of normal intellectual potential" the opportunity to achieve their potential); 2) 51 additional teachers for the more severely mentally retarded (to satisfy the waiting list and newly identified pupils, and to provide for them the possibility of achieving some degree of self-sufficiency); 3) 70 additional positions for the emotionally disturbed (to permit behavior problems to receive necessary attention and, as a positive by-product, to lessen disruptive situations that plague regular classrooms); 4) an allocation of $2,300,000 for tuition grants (to provide for waiting list children for whom there is no appropriate public school program and to cover anticipated increases in charges); 5) 5 *pre*-Kindergarten classes (to begin a modest, urgently needed program for children identified as handicapped early in life); 6) an additional 30 aides (to enable more productive utilization of teachers' time in special classes which are above the 8:1 pupil-teacher ratio); and 7) basic minimum funds for necessary materials and equipment.

We earnestly request your careful consideration of these demonstrated needs. Your failure to provide for them will force 1,800 children to wait another precious year, and to lose an irretrievable part of their already limited chance to salvage their lives.

GENERAL COMMENTS

1. Limited screening and diagnostic procedures make it impossible to determine accurate statistics for the occurence of handicapping conditions among D.C. pupils. However, the enormity of the gap between numbers served and probable incidence is obvious (see Table 1).
2. Increased resources for diagnosis, evaluation and periodic reassessment are essential.
3. Appropriate programs must be made available to children identified as suspected of having handicaps.
4. Adequate provision must be made for the sizable number of educable mentally retarded who have been deprived of special classes as a result of misinterpretation of the Wright decision.
5. Expanded vocational training is necessary in order to enable the handicapped to become productive and avoid long-term cost to society.
6. Disabilities are more readily ameliorated by early remediation and treatment. Pre-school programs for the handicapped must be instituted.
7. To fulfill the needs of the current waiting list would provide for less than 10% of the children in need of special services (1,754 of 19,837 children—see Tables 1 and 2).
8. Funds are needed to provide tuition grants for instruction in private institutions when adequate programs are not available in the public schools (see Tables 3 and 4).
9. A comprehensive plan for special education should be devised, funded, and implemented so that handicapped children can realize and enjoy their potential and become useful members of society.

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Educable	9,000	(1)	[2] 9,000
Trainable	1,500	625	875
Speech handicapped (3.5 percent)	5,355	(1)	[2] 5,355
Emotionally disturbed (2 percent)	3,060	82	2,534
Special education program "Socially Maladjusted"		[3] 444	
Learning disability (1 percent)	1,533	87	1,446
Hearing impaired and deaf (0.575 percent)	778	40	738
Crippled or health impaired (0.5 percent)	767	211	556
Visually handicapped (0.1 percent)	153	31	121
Total estimate (total incidence 14.675 percent)	22,146	2,309	[2] 19,837
Served by Department of Special Education		[3] 1,200	
Nonpublic resources and tuition grants		665	
Socially maladjusted [4]		444	

[1] None in special education.
[2] Minimal supportive services for a small portion through regular instructional program.
[3] Includes 124 children in developmental center pilot programs; detail above totals 1,076 children.
[4] Served in regular instruction program.

Source of information on numbers served: Office of Director of Special Education.

TABLE 2.—*Waiting Lists of Handicapped Children in the District of Columbia: School Year: 1970–71 (as of April 1, 1970)*

Waiting list for placement in special classes—	
Trainable mentally retarded	467
Children with learning disabilities	189
Emotionally disturbed or "socially maladjusted"	[1] 700

[1] Minimum estimate

These children have all been diagnosed and evaluated. School authorities have determined that they require special education. Yet, the Alternative I Budget submitted by the School Board ($7,033,500 for special education) does not fully satisfy these acknowledged needs. The proposed D.C. Council budget now under consideration provides even less support.

Waiting list for tuition grants—Various handicapping conditions	398
Total	1,754

TABLE 3.—*Statement in Special Education Information Bulletin: 1970–71* [1]

This statement unfortunately, is highly misleading. The total allocation for tuition grants for FY 1971, $1,205,000, had been assigned prior to the opening of school in September. Approved applications for tuition aid for 398 children have been placed in a "waiting list" category due to lack of funds (see Table 4). The Department of Special Education has discouraged additional applications because it is unable to provide support.

Tuition Grants

Funds are provided for tuition grants for instruction in private institutions when an adequate program is not available in the public schools. Tuition grants *are provided for all* [2] severely handicapped children whose needs cannot be met in the public schools. (See Board of Education policy statement for June 17, 1970.)

Medical and psychological examinations required.

Documented, definitive information required.

Pupils ages 2 through 21.

Grant not to exceed $4,000 per year, unless additional amount permitted by

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[1] Page 13.
[2] Emphasis added.

Appeals Committee.
Membership:

521 pupils are receiving tuition—

Blind	40
Deaf	192
Emotionally disturbed	79
Health impaired	10
Mentally retarded	138
Multiply handicapped	32
Neurologically impaired	30

These pupils are enrolled in 36 private schools.

TABLE 4.—"WAITING LIST" CHILDREN CERTIFIED AS ELIGIBLE FOR TUITION GRANTS, SCHOOL YEAR 1970–71

	As of Nov. 18, 1970	As of Apr. 1, 1971
Total	336	398
Blind	1	(1)
Deaf	4	(1)
Emotionally disturbed	124	(1)
Health impaired	5	(1)
Hearing impaired	4	(1)
Mentally retarded	103	(1)
Multiply handicapped	5	(1)
Neurologically impaired	90	(1)

[1] Categorical breakdown not presently available.

Source: Mrs. Mamie Lindo, supervising director, Department of Special Education, District of Columbia public schools.

By early December 1970, an additional 6 children had been added to the waiting list, making a total of 342. At that time, according to Mrs. Lindo's estimates, approximately 200 of these children were in the public schools, inappropriately placed; an estimated 100 were in private schools, with their parents paying the total costs and not even being reimbursed for the system's average per pupil expenditure for normal children. The remainder, 30 to 40 children, were at home receiving no school experience. Those in the last group are excluded from school because of profound disability or severely disruptive behavior.

As of April 1, 1971, the waiting list had increased to 398 children. Thus, at a minimum, there are 919 children currently eligible for tuition grants of which only 521 receive aid. While the number of children requiring assistance is increasing, the anticipated support is decreasing. A recent report from the Department of Special Education projects that only a total of 484 children will be funded by tuition grants during the 1971–72 school year. The estimates given are as follows:

	Number	Estimated per pupil cost
Blind	30	$4,931
Deaf	129	1,787
Emotional disturbed	87	3,452
Hearing impaired	29	2,653
Mentally retarded	141	1,684
Multiply handicapped and health impaired	38	1,343
Neurologically impaired	30	2,792

Because of anticipated increases in tuition charges by private schools, tuition grants to the above group are expected to exhaust the proposed allocation of $1,300,000. An additional $1 million is required to satisfy the present waiting list (that is, approximately 400 grants at an average cost of $2,500). This still would not provide for newly identified handicapped children whose needs cannot be met by programs in the public schools.

WASHINGTON, D.C., *September 24, 1970.*

DR. HUGH J. SCOTT,
D.C. Public Schools, Presidential Bldg., Washington, D.C.

DEAR DR. SCOTT: Concerned Citizens for Exceptional Children is an organization which was formed two years ago because of the overlapping efforts to obtain better programs for the handicapped. Each of the organizations on the attached list represent specific handicapping disorders and send a representative to our meetings. Membership also includes parents, educators, psychologists and other interested people.

Services to handicapped children offered by the District School system are at this time critically deficient. We feel the entire school system, from the Board of Education through the highest echelon of the school administrators, to the principals and teachers of the neighborhood schools, share the responsibility for this situation, along with the District Government and the Congress of the United States.

The most frustrating aspect of our organization's efforts in the past has been the almost total lack of responsiveness that we have met. We are often given sympathetic hearings and assurances that our requests will be carried out, but there is very little consequent action.

We asked to meet with you at this time to present information to you in order to shorten the time it would naturally take you to apprise yourself of the current situation, and to stress how urgent the needs of the children are. We realize you may have difficulty believing us when we tell you how severe the problem is, but we hope to document our comments.

There are a number of major areas of deficiency:

I: *There is no comprehensive preschool screening for handicapping conditions—*

(*a*) Project headstart reaches only ⅓ of District children.

(*b*) There is no census of children of school age, let alone preschool age, although required by law. The health services which could serve the schools, are fragmented.

II: *There is no adequate program of diagnostic services for school age children—*

(*a*) At present, responsibility for diagnosis and referral of handicapped children is in the hands of the elementary school principal. Besides being generally overworked, many principals have neither the training nor the interest to adequately carry out this responsibility. It is our experience that principals want to feel that they can handle all of the children in their school building; since so few schools have special classes, these children are often kept far too long in regular classes. An additional problem is that where referrals do take place, principals and teachers are so demoralized by the lack of any placement, following testing, that they come to feel that testing itself is a waste of time. There is no teacher or principal education about the resources for handicapped children, and often there is no one in any given school who can provide any such information to parents.

(*b*) Finally, the school administration has a generally passive attitude towards screening and testing, leaving the matter up to parents and teachers, who may or may not then be able to help the involved children.

III: *There is a chaotic system of referral for services—*

(*a*) Several alternative recommendations are often made by Pupil Personnel workers for any given handicapped child because of the awareness by these workers of the terrible lack of actual placement possibilities. Even if the poorest of these recommendations is used, the record will indicate that an adequate placement has been made. It then appears that far more children are being adquately served than is actually the case. For instance, a referral to the MIND program (a tutorial program for slow learners under regular instruction) of an emotionally disturbed child, is treated as an adequate placement for the records. Thus, there is no indication, statistically of this deficiency of service, which should be used for future planning.

(*b*) Finally, there is a tremendous reduplication of effort caused by the public school very often not accepting testing results of reputable outside testing services, such as Gales Clinic, Howard University, private doctors, P Street Clinic, etc. Reputable diagnostic clinics such as Howard University, test and diagnose most adequately the deficiencies found in the children who come to them, only to know that the educational needs of most of these children will go unmet. Mrs. Mitzi Parks, Child Development Specialist at Howard University's Diagnostic

Center, had this to say at CCEC's February 5, 1970, meeting: "More than half of our referrals come from the District Public Schools—over half are mentally retarded. I have a list of names of 300 children, tested by our Center, who are misplaced in the public school. They are either educable retardates in the severely mentally retarded program, or educable retardates and children with learning disabilities in the MIND program, and various other combinations of misplacements."

IV: *There is a lack of follow-up testing*—

(*a*) Children are not retested at adequate, persistent intervals so that placement failures tend to persist and handicaps become compounded.

(b) Children who may have achieved maximum benefit from a given program and are ready to return to the regular classroom are held back.

(*c*) The failure of follow-up testing makes the assessment of programs impossible.

V: *Lack of special education programs*—

We will indicate at this point only the most serious deficits and give you supplementary material that will indicate the full scope of the problem.

(*a*) *Retardation.*—There is *no* program for the organically impaired educable retardate in our school system. Since 1967, and the Skolley Wright Decision, you will find these children scattered all over our school system—in the SMR program, in the MIND program, in regular classrooms, in private schools and on their waiting lists, at home, on the streets, and on the waiting lists of Diagnostic Centers for placement. The public school has no waiting list because in their opinion, this group of children is getting what they need in the public school.

For the functionally retarded, there is the MIND program *in a few schools*, which has never been evaluated for its efficacy. According to the President's Committee on Mental Retardation, "The prevalence of mental retardation will be found to be considerably greater than 3% among the lowest socio-economic levels."* The MIND program serves approximately 2500 children.

*The Problem of Mental Retardation, President's Committee on Mental Retardation, 1969, pgs. 16 and 17.

The program which our school system persists in calling Severely Mentally Retarded (SMR), IQ range between 36 and 51, and which in the profession is known as the Moderately Retarded range (trainable), has some urgent, immediate needs:

The existing program now services 679 children manned by 57 teachers and is critically in need of a reduction of pupil teacher ratio and teacher's aides. The Board of Education set the ratio of these classes at 8 to 1 and in order to comply with this rule we need 28 additional classes.

An additional *340* children, 325 of them in regular classrooms, 15 at home, have been diagnosed by Pupil Personnel Services as needing placement in the SMR special classes. This brings the need for 42 classes to take care of the waiting list.

(*b*) *Children with Learning Disabilities* (*CLD*).—By *conservative* estimates, 1500 children in the District have specific learning disabilities and there exist in our school system, classes for 80 children. 130 children, now in regular classrooms have been diagnosed by Pupil Personnel Services as requiring placement in special classes, with trained teachers.

(*c*) *The Emotionally Disturbed.*—The Mental Health Association of the District of Columbia, estimates a 295,000 District population of children up to age 19 (fact sheet attached). By National percentages, 1,770 of these children are psychotic, 6,000 to 9,000 are severely disturbed, and anywhere from 24,000 to 30,000 need help of one kind or another with emotional problems. The magnitude of this problem for our school system and its children, becomes abundantly evident when Pupil Personnel Services' records disclose that 10,000 children in our school system last year were the subject of parent-teacher consultation, 340 children were suspended and 3,651 children were referred to Pupil Personnel Services on Form 205 for testing—all having behavioral difficulties.

Our school resources for children with emotional and behavioral problems consist of:

Social Adjustment Classes (no one in CCEC can determine what sort of program this really is and what kind of need it is supposed to help)

	Children
Elementary	112
Junior High	216
	328
Boy's Junior and Senior High	36
Twilight program (approximately)	60
Total	424

An additional 78 students receive tuition grants to private special schools, bringing the total up to 502 children.

There are 13,790 children LOST between the MIND program, Junior Village, on the streets, in jails and courts, and then there are the quiet ones.

No secondary program exists for girls.

(*d*) *Speech, hearing, and sight conservation.*—There is a critical need of services, supplies, and equipment in these areas. Our schools list the following programs:

	Children
Hearing	64
Sight (with 2 classroom teachers and 6 itinerant teachers)	87
Rubella affected	18
Total	169

The more severe blind and deaf children are receiving tuition for private special education.

(*a*) Gross inadequacy of secondary special education and lack of structured, meaningful job training. Most special services, like CLD classes are discontinued at the secondary level.

VI: *Despite the shocking deficiencies noted above, there is an attitude of complacency on the part of the school system for a variety of reasons*—

(*a*) inadequate leadership.

(*b*) a general and fallacious advocacy of placing all children in regular classrooms as an actual rather than an ideal policy.

(*c*) the education of handicapped children is considered a matter of luxury compared with the pressing problems of general education.

(*d*) The issue of handicapped children has been dealt with, politically in the following manner: as a result of the Skelley Wright Decision following the Hobson-Hansen suit, despite clear and specific ruling of the decree to the contrary, the public school in the District of Columbia, has maintained that self-contained classes for the handicapped was a form of segregation.

(*e*) this policy of self deception as noted above, by considering children adequately served if they are listed in any program at all, would indicate many of them are grossly misplaced.

(*f*) many administrators seem to be more preoccupied with job status and maintenance of empires and bureaucratic formality than with the welfare of the children involved.

(*g*) administrators feel it is the parents' problem rather than theirs, to see that the child gets proper placement.

(*h*) the administration tends to discredit any other persons concerned with the area of the handicapped and fails to communicate with outside agencies in the field who could be a tremendous resource. On the other hand, parents and even school personnel who need help cannot reach the Department of Special Education for guidance and advice. Parents with children in the SMR program are too often not informed about rudimentary and vital matters such as trips, transportation, opening of school, changes in placement, etc.

VII: *Inadequate Planning*—

(*a*) Special education funds and resources are most often cut in favor of other needs. Organizations such as ours devote many hours of their time preparing and presenting testimony to the Board of Education, the District Government and both Houses of Congress, specifically making known the needs and pressing for adequate funding. They have succeeded in getting funds allocated to special education, only to have the school system divert those funds to other programs. Here, we would like to mention the 1970 funds appropriated for an Assistant Superintendent of Special Education and that CCEC has been promised the opportunity to sit in on the selection committee proceedings. Also, in the area of teachers' aides for the 1970 budget—70 were requested—18 were appropriated—funds for 6 or 7 recently "unfrozen". Where is the balance?

(*b*) The school administration does not share the community's concern about the extent or urgency of problems in the area of educating the handicapped. Thus, while 1500 children in need of one type of program alone, are not getting served, the administration is content with the receipt of funds for token services in the yearly school budget. They put the pursuit and acquisition on the parents and organizations like CCEC.

(*c*) Special education classroom space is dependent on whether or not a given school principal feels she has an extra room to spare.

(*d*) Failure to follow up prescribed, paid-for guidelines of the Passow Report. An outgrowth of this report was the Working Party's paper on Special Education, which implemented the recommendations of the Passow Study. This plan was approved by the Board of Education. A copy of it is attached.

(*e*) Failure to adequately apply for, use and integrate all federal funds available for the education of the handicapped.

(*f*) Failure to assist families where private school placements have been impossible.

(*g*) Failure to streamline and improve the method of renewing grants and issuing new grants.

VIII: *Additional urgent problems—*

(*a*) The emotionally disturbed student must be separated from the mentally retarded child.

(*b*) The acquisition and distribution of supplies and equipment.

We feel a good number of the deficiencies listed above are specifically attributable to certain individuals in the administration, and, frankly, doubt that they are capable of change and should be replaced. This statement is based on repeated, constructive efforts on our part, to obtain some meaningful change in services.

We are not seeking for these handicapped children more than is their right—the right to an education within their limits and potentials. The entire school system can only profit and be strengthened if the weaker of its members, and usually the last to be considered, are provided for.

Sincerely yours,

RALPH WITTENBERG,
President, Concerned Citizens for Exceptional Children.

Attachments: List of member organizations, Pertinent pamphlets and material.

CONCERNED CITIZENS FOR EXCEPTIONAL CHILDREN OF THE DISTRICT OF COLUMBIA

Washington, D.C., January 14, 1970.

In the wake of the Skelley Wright Decision handed down in the Hobson v Hansen suit, the District of Columbia Public Schools abolished its track system in September 1967. As the public school administration interpreted this part of the Decision, it meant the redistribution of almost all children into the mainstream, with emphasis placed on eradication of past practices that discriminated against those children found in the so-called basic and general tracks.

The only classes left undisturbed were those for the trainable retardate, about four classes for children with learning disabilities, a group of emotionally disturbed students in "social adjustment" classes, and the orthopedically handicapped.

To assist those children found unable to hold their own in the regular classroom, a plan called MIND—Meeting Individual Needs Daily—was formulated and is now in operation in some 50 out of 143 elementary schools and 28 out of 30 junior high schools, servicing a total of approximately 2,580 students. Some new developments have also taken place in the Department of Special Education. Are the educational plans set in motion by our school system since the Skelley Wright Decision, proving effective?

Concerned Citizens for Exceptional Children, comprised of over 15 agencies and organizations servicing all types of handicapped children, feel it is time to review the approaches to and the philosophy of educating all children with learning problems, especially in the area of retardation.

On Thursday, February 5, 1970, at the National Education Association Building, 1201 M Street, N.W., at 8 p.m. we would like to address ourselves to these matters, bringing to bear the thoughts of some school administrators, board members, parents, teachers, university people, U.S. Government specialists, psychologists, etc. The issue is a vital one and we urge you to attend. This invitation has been specifically directed to you, and we would appreciate knowing if you are unable to attend or to appoint a representative. You may write or call at 363-6007 after 3:30 p.m.

Sincerely yours,

Rosalie Iadarola,
Corresponding Secretary.

Enclosures 1. significant pertinent events; 2. chart of services.

SIGNIFICANT PERTINENT EVENTS

1967	
June 19	Skelley Wright Decision handed down in *Hobson* v. *Hansen*
September	Passow Report issued
September	Abolishment of track system as practiced under Dr. Hansen's administration
October	Executive Study Group and Community Council formed to assign specific sections of the Passow Report to Working Parties commissioned to formulate plans for implementation of the report
December	Board of Education voted to accept the program called MIND, worked out by Pupil Personnel Services, to help those children now in the mainstream and formerly in the basic track, or any child unable to cope with a full day in the regular classroom
1968	
March	MIND was instituted on a pilot basis
June	The Working Party on Special Education issued its recommendations to the Executive Study Group
October	The Department of Special Education became a separate department
October	Dr. Manning ordered the MIND program expanded to the entire school system giving the program to the Department of Special Education to administer
1969	
November	MIND program became part of regular instruction, administered under Elementary and Secondary Departments

SPECIAL CLASSES AND SUPPORTIVE SERVICES FOR EXCEPTIONAL CHILDREN IN THE DISTRICT SCHOOLS AS OF OCTOBER 1969

ADMINISTRATED BY DEPARTMENT OF SPECIAL EDUCATION

Special classes	Number of classes	Number of of pupils	Waiting
1. Early childhood (Rubella) supervised by developmental center:			
Elementary	2	12	
2. Children with learning dis. (including 1 CLD and 1 aphasic early years under Developmental Center):			
Elementary	11	82	
Junior high			
Senior high			
3. Occupational classes (overaged for grade level but not old enough for Junior high programs): Elementary	5	32	
4. Social adjustment (including twilight classes at Hine Junior High and 5 engineered classrooms)			
Elementary	20	150	
Junior high	28	294	
Senior high			
Total	48	444	
5. Trainable mentally retarded (including 5 transitional classes for those working above trainable level and those not benefiting from mind) and 3 kindergarden classes.			
Elementary	41	375	
Junior high	8	153	
Senior high	2	26	70
Total	51	554	
6. Educable mentally retarded:	0	0	
7. Hearing impaired:			
Elementary	4	33	
Junior high	1	11	
Senior high			
Total	5	44	
8. Sight impaired:			
Elementary	2	18	
Junior high			
Senior high			
9. Boys' junior-senior high (emotionally disturbed and socially maladjusted): Junior–senior	5	70	
10. Sharpe Health School (orthopedically Handicapped and other health problems):			
Elementary	12	125	
Junior high	4	44	
Senior high	4	28	
Total	20	197	
Grant total (Teachers, 149; schools, 73)	149	1,453	

SPECIAL SUPPORTIVE SERVICES

Crisis-Resource Centers	12		
Diagnostic prescriptive centers	4	126	20
MIND Centers (Transferred in November 1969 to elementary and secondary instructional units)			
For children experiencing academic difficulty and assessed by child and youth study (pupil personnel services)			
Elementary	62		
Junior High	50		
Total		2,580	2,256
Visiting Instruction Corps	46	263	
6 Itinerant teachers for visually impaired			
Administered by Regular Instructional Elementary and Secondary Units			

SUPPORTIVE TO REGULAR CLASSROOM AND SPECIAL EDUCATION

Speech and hearing clinic			
Pupil personnel services, testing and counselors			
Reading clinic			
MIND program since November 1969			

Source: Enrollment figures from Dept. of Special Education.

CONCERNED CITIZENS FOR EXCEPTIONAL CHILDREN OF THE DISTRICT OF COLUMBIA, c/o 3422 OLIVER ST., NW., WASHINGTON, D.C. 20015

MEETING OF FEBRUARY 5, 1970, NATIONAL EDUCATION ASSOCIATION BUILDING

Good Evening, and welcome to all of you.

It is the hope of parents present and not present tonight, that this assembly leads to a path which will bring some peace to the heart of many a parent whose child's capacity to learn is not normal, either because he was born to us damaged or because the vicissitudes of life have stunted his potential for learning. There are parents here having children on many levels of exceptionality, no doubt including the gifted, and Concerned Citizens for Exceptional Children hope they will feel free to enter the open discussion period; as we hope everyone will.

Most of you have received with our letter of invitation, a description of existing special classes and other services, with enrollment figures, plus pertinent data which we hope you have reviewed. Since sending this data out the issues have been further clarified. As they relate directly to the content of this meeting, we quote from the abbreviated minutes of the November 24 Board of Education minutes, recommendations made by the Superintendent and accepted by the Board Members:

1. Transfer the MIND program from Special Education to Division of Instruction.

2. Develop specific criteria for placement of severely handicapped children in special classes by the Department of Pupil Personnel Services and Special Education.

3. Reassess all pupils in CLD (children with learning disabilities) and other special classes concurring to the newly developed criteria and the pupils who meet this criteria will be placed in special classes and the remainder will be placed in the MIND program.

4. Direct the supervising director of the MIND program to prepare a statement of immediate and projected needs, equipment, supplies, space and personnel for use 1970–71 in order to effect an orderly transfer and expansion of the program.

(We wonder if this expansion can possibly be reflected in the 1971 budget now before the City Council.)

5. Direct the supervising director of the MIND program to work with the director of Staff Development in planning a program for training teachers in the MIND program and explore possible sources of funds for this purpose.

6. Study the personnel requirements of the MIND program and make whatever transfers and adjustments that are deemed necessary to insure the smooth operation of the program.

These sweeping recommendations of November 24, now in the process of administratively being carried out, make it ever more necessary to air and probe areas of concern to determine where our concern is justified and where it may not be justified.

Some questions which reflect our concerns are:

What criteria defining severely handicapped children have been evolved by the Departments of Pupil Personnel Services and Special Education? Who are on the committees developing these criteria? With this knowledge on hand, we can then determine the kinds of needs the MIND program is expected to support. Certainly, these criteria should be made public and transmitted to interested organizations. We would think that the Board Members would find it most necessary to have these criteria to study. These criteria will not only shape the needs of three vital departments—Special Education, Pupil Personnel Services and Regular Instruction—they will also shape the character of the entire school system as they relate to children's needs.

Is the MIND program being expanded because it has proven it can and has succeeded in giving the necessary support to that group of children with multiple needs ranging between severely handicapped and normal? Which needs is MIND reaching and which needs is it failing? What measures are built into the MIND program to insure that those children not progressing will be referred, swiftly, to additional resources? In this connection, do the Departments of regular instruction, Pupil Personnel Services and Special Education have a viable, cooperative working relationship vital to the success of dealing with "MIND dropouts?" as they become identified? Is the Transitional Class to serve the needs of the "MIND dropout?" If so, how many children are on the waiting list and what educational needs do they represent. Does a bottleneck appear at the point where special education programs are needed and what are the resaons for a bottleneck?

Where does the educable mentally retarded child fit into this whole picture? In the District of Columbia Public School system, who is the educable mentally retarded child and can the MIND program help all EMR children? We understand that entry into the severely retarded classes (trainables) required an IQ functioning level of up to 55 and has been upped to 65. What does this mean? How will the new criteria now being worked on change this?

If there are some educable mentally retarded children who cannot benefit from the MIND program, does the public school administration consider it illegal under the Skelly Wright Decision to program self-contained classes for the EMR, CLD or any child when it is professionally determined this would be the best arrangement for his progress?

As Pupil Personnel Services identifies specific needs, do they have complete freedom to professionally prescribe and choose from a flexible arrangement of programs, or are they forced to accept MIND as a placement when they know that certain children need more than MIND?

These are but a few questions. More will probably emerge during the open discussion period, along with some possible answers, we hope.

We parents of children with handicaps, ranging from severe, to moderate, to mild, to borderline, certainly do not want our children walled off from society. Nor are we overly concerned or fearful about the stigma of labels, especially if we suspect that in the zealousness of the public school to eradicate this stigma, children's special needs get blurred and lost, thereby impairing or destroying what potentials these children do have.

We need to know that our children will be given the benefit of a professional, well-thought out, long-range school-life plan, which fits their needs and has the flexibility to grow with their needs, which will include, first and foremost—good teachers—specially trained to work with children having special needs.

We need to be sure that those children kept in the mainstream are kept there because of professional determination, evaluation and conviction that this is the best place for their progress and not because the administration may be convinced that the mainstream is a means of complying with Judge Skelly Wright's Decision relative to abolishment of the track system.

Parents, black and white, educated and uneducated, rich and poor, are finding each other and working together—seeking one thing from the public school system in the District of Columbia—quality education equal to the needs of their children*!*

The Federal Government is more active today than ever before in funding programs for the handicapped so that they may have a chance to take their place in society. Now, the Public Schools must face the fact they can no longer concern themselves mainly with educating children who *can* cope—they must concentrate their resources, utilizing all the brains and help they can muster, in and outside of the school system, to help those who *cannot* cope—in order to put and keep those children in the mainstream of life also*!*

We have asked a few people to make relevant comments. Then there will be an open discussion period.

1. Mrs. Dorothy Hobbs, supervising Director of the MIND program for the District Public schools. Mrs. Hobbs could not be here tonight as some urgent family problems called her out of town. She has sent a description of the aims and philosophy of the MIND program which she has requested be read.
2. Mrs. Mitzi Parks, child education specialist with the Child Development Center at Howard University.
3. Dr. Gertrude Justison—served 4 yrs. on Task Force for Special Education of Consortium of Universities, 4 yrs. on education committee of Mental Retardation Planning Council 1 yr on working party for special education to implement the Passow recommendations under the Executive Study Group, Director of Special Education at Howard University (teacher training), expert witness in the Hobson v Hansen suit; Now at Howard County, Md. in public school system Director of the Child Study Center.
4. Mrs. Mary Young, Center Director for area 2 (southeast) with Pupil Personnel Services of District Public Schools.
5. Miss Jeanne Walton, former teacher, field representative for Washington Teachers Union.
6. Dr. Maurice Fouracre, involved in teacher training for special education since 1942, affiliated with Maryland University, Director of St. John's Child Development Center.

(Mrs.) ROSALIE IADAROLA,
Parent of an Educable Mentally Retarded Child.

[From the Sunday Star, Washington, D.C., Feb. 15, 1970]

PARENTS, EDUCATORS CRITICIZE D.C. SLOW-LEARNER PROGRAM

(By Wayne Corey, Star Special Writer)

Angry parents and concerned educators have bitterly accused the District school board's Special Education Department of paying too little attention to the MIND (Meeting Individual Needs Daily) program, which endeavors to provide special individual instruction to handicapped or "slow learning" children.

On Feb. 5, Concerned Citizens for Exceptional Children (CCEC) met to examine the present state of the program, which concerns blind and deaf children, as well as those who have less than average intelligence but who are not sufficiently impaired to be considered retarded.

There has been little publicity about the program, yet 25 to 30 percent of all school-age children may actually require some form of individualized instruction, according to Dr. Maurice Fouracre of the University of Maryland and the St. John's Child Development Center.

PERCENTAGE HIGHER HERE

CCEC believes the percentage of District children requiring special instruction is considerably higher than the national average, and it is extremely unhappy with what it feels is a lock of concern for the program among school authorities.

At present, nearly 30 organizations are participating in the program in D.C. schools. Approximately 2,900 handicapped children are involved, with an additional 2,300 waiting to enter the program.

A former MIND teacher asserted that teacher are ill-trained to cope with handicapped children, who, frustrated over inability to keep up with other students, become distruptive.

Dr. Fouracre said "the MIND program has been a dumping ground . . . a convenience" for many regular teachers who do not want to be bothered with handicapped or slow-learning children. Thus the children often cannot receive proper education in MIND classes, either.

Another problem encountered by MIND proponents is an apparently greater concern for severely retarded children over those who are nearly normal.

"Children who are retarded are lost in the scheme of things, while severe deviants are given greatest attention," said Dr. Gertrude Justison, a former member of the education committee of the Mental Retardation Planning Council.

Mrs. Mary Young, a team member of the D.C. Pupil Personnel Services, noted that many children, who may be merely slow learners are labeled "retarded" because of improper or inadequate diagnosis and insufficient testing.

"Is a 10-year-old girl, who raises five younger children, but who cannot read, retarded?" she asked.

A parent of an "educable" mentally retarded child, Mrs. Rosalie Iadarola, questioned the on-going expansion of the MIND program and whether it can support needs of children ranging from severely handicapped to normal.

THE WASHINGTON TEACHER'S UNION

1. The Wright Decree did abolish the track system. It did not at all deal with special education. The school-system is free to form special classes for retarded children and other children with learning disabilities and emotional disturbances as long as assignment to such classes is made on the basis of individual, competent diagnosis and prescription, not on the basis of achievement or IQ tests.

2. The Mind Program has not worked for the following reasons:

A. Children for the program are not carefully selected on the basis of individual diagnosis and prescription.[1]

B. Only a handful of the children who need the program are reached.

C. The classroom teacher has not been instructed as to the purposes of the MIND program, the particular problems of the child she sends to the MIND teacher and how she can work most productively with the child in the regular classroom.

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[1] There should be a diagnostic and prescriptive teaching program with ready access to all needed services.

D. MIND teachers are not always carefully selected and do not always possess the necessary qualifications. In several cases, secondary teachers with absolutely no teaching experience were assigned to elementary MIND classes.

E. Some principals interfere with the program by assigning other duties to the MIND teachers.

F. In some buildings, materials, equipment and space are far from adequate.

Special Miseducation

THE POLITICS OF SPECIAL EDUCATION

(By Em Hall)

By statute and supporting regulations all states either permit or require their local school boards to maintain programs for children with certain physical, mental, or emotional disabilities. Definitions of these "exceptional" needs vary from jurisdiction to jurisdiction as do the specific terms of the enabling legislations. But all the statutes are designed to establish mandatory classifications of children who are not expected to profit from regular classroom offerings and who, if they are to receive any measure of equal educational opportunity, must get differentiated treatment.

The umbrella term, special education, which most of these statutes take as their point of departure, actually covers many different problems. Factors involving emotional handicaps, various cultural disadvantages, physical brain damage, perceptual-motor distortions, and mental retardation can surface in an infinite number of ways in the life of a particular child. The appearance of one factor does not imply the presence of any other. Emotionally disturbed children are often extremely intelligent. Mental retardates may not be emotionally imbalanced. Children with perceptual handicaps may be neither disturbed nor retarded.

But all the excepted characteristics share common statutory recognition by the states. As it turns out, many have also come to share single—often inappropriate—measures for their identification and single—often inappropriate—services for the diverse special needs they represent. Programs which might succeed if they were addressed to particular disabilities have tried to reach them all and so end responding to none. A Progressive movement, state-level reform intended to recognize that certain public school children would receive little education unless they were given some supplemental services has come down to the present in the form of a system that denies them any education at all.

Responsibility for this state of affairs—as well as for the maintenance of most of the programs—falls to the school districts. With the exception of those few states which finance and operate independent special schools, statutes impose only a broad duty on local boards to maintain adequate programs and create a statutory right on the part of eligible school children within a particular district to demand them. While some state boards of education have promulgated extensive administrative regulations governing local practices in this area, responsibility for determining need and eligibility, placing particular children in particular classes, and operating those special classrooms remains with the local boards.

BOSTON: CASE STUDY

If the special education situation in Boston is any indication of what is going on in other urban areas, local systems everywhere may be violating their own and their state's regulations, state statutes, and state and federal constitutions. Based on the incidence of state recognized "special needs" in the national population, Boston social psychologists estimate almost a quarter of the 96,000 local school children should be eligible for one of the state-mandated special programs without which the "exceptional" student cannot make educational progress.[1]

But some Boston programs reach less than a quarter of the students these statistics predict as eligible. For example, 3% of urban school children will prove to be perceptually handicapped. Of the 3000 cases this figure yields in the Boston population, the local school administration has identified only 150 eligible students and is delivering services to only 110 of them. Similarly, two children in every 1000 will prove to be severely emotionally disturbed and 15 in every 100 could benefit from extensive personnel counseling. Boston has placed 48 in the full-time classes that it maintains in the public system for emotionally disturbed children and has made alternative arrangements for 70 others.

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[1] Hard statistics are extremely difficult to come by in this area. Definitions vary from study to study and from locale to locale; different measurement instruments locate different numbers in the various categories. The Boston estimates, probably on the high side, are derived from *A Task Force Study On Children Out of School* being prepared by Boston University Mental Health Clinic. For a more conservative national estimate see Remaine Mackie, *Special Education in the United States: Statistics 1948–1966* (New York: Teachers College Press—Columbia University, 1969).

Another Boston "special education" program, however, reaches many more children than statistics predict it should. The incidence of mental retardation in the general population suggests that 1500 Boston children ought to qualify for the state-mandated classes for children with a certain defined low level of learning ability. Currently 2700 children have been placed in special classes for the mentally retarded and another 1100 have been put on waiting lists. Some of those waiting for "space to become available" continue to attend regular classes, but others are told to stay at home, out of school, until they can be placed.

There are a variety of reasons for the gross underpopulation of some programs and the gross overpopulation of others. To begin with, screening devices for the identification of these problems are often not merely inadequate but non-existent, and in direct violation of specific state board of education provisions governing the operation of these programs.

One Massachusetts statute, for example, requires local administrations to take an annual census of mentally retarded children within each local school district. The School Committee claims the police department takes it; the police have never heard of it; and the city's annual report to the state board of education lays the duty on the shoulders of the individual school principals. In the meantime, the Boston director of the Department of Special Education says his staff is "digging them (kids with special needs) out of the attics". Another regulation requiring biennial physical and mental examinations is either openly disregarded or observed by checking periodically for lice in the student's hair.

Under these circumstances, assignment to special classes is apt to be both irrational and unrelated to the special needs of a particular child. Indeed in some sections of the city, administrators regard the classes as convenient places for dumping children who prove bothersome in the regular classrooms. Teachers, frustrated by their inability to control particular students and understandably worried about the effect of one disruptive child on the whole class, often seek placement as a way of ridding themselves of a difficult behavioral problem.

And so many more boys than girls are assigned to special classes in the generally female atmosphere of Boston's elementary schools, and many more blacks are placed than whites in the distinctly Irish atmosphere of the city's classrooms. In many of those cases there is no prior testing, no post-placement testing, no notice to parents, no record, and no attention to the state regulations which require them all.

TESTING

Even when all the formal procedures are followed, assignment practices can prove discriminatory. Minimum state criteria require, for example, only the use of either Stanford-Binet or Wechsler Intelligence Scale for Children (WISC) tests for diagnosis of special needs. Only those children who are referred by particular teachers as difficult in class take them. As it turns out, the instruments are often too insensitive to reflect real need and those who are asked to take them are the most likely to come from the kind of backgrounds that skew the test results.

Low scores on either or both of these tests are formally prerequisite to placement in Boston's special classes for the mentally retarded. Recent research reveals that these can be—and often are—the results of a variety of factors other than mental retardation.[2] Extremely bright, emotionally disturbed children often score low enough to be classified as "educable" or "trainable" on the single standard the tests yield. Perceptually handicapped children cannot manipulate the visual problems posed even though that has nothing to do with other characteristics measured and may have little to do with their success in school. Children from minority cultures and non-English backgrounds different from those on whom the test is standardized have greater trouble merely comprehending the instructions and so score lower for that reason.

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[2] See, e.g., "The Incidence of Pseudo-Retardation in a Clinical Population," 109 *American Journal of Diseases of Children* 432 (May 1965). This article concludes with specific suggestions for supplemental, diagnostic tests which can correct for many of the misreadings gleaned from the Stanford-Binets and the WISC's.

Any of these irrelevant but distorting factors should be picked up by sensitive trained testors. Stanford-Binets and WISC's are individually administered, individually scored measures. Properly trained test administrators can pick up extraneous behavioral, physiological, or cultural factors which might skew the results of a test aimed at determining the relative level of something quite different.

But Boston testors are all ex-teachers, rewarded for years of good service by promotion to lower bureaucratic posts widely regarded as enviable and easy positions. While most meet the letter of a formal state requirement calling for "qualified testors" few are actually trained in the art of test giving, few are trained to recognize extraneous mannerisms in the test takers which might indicate some reason for a low score other than mental retardation, few are widely experienced in either the culture or the language of those minority groups who most often find their way into the programs, and few are willing to commit themselves to the considerable amount of time and energy it takes to give and score one test accurately and responsibly.

No wonder, then, that independent agencies in Boston are beginning to find that in some instances more than half of the children in local special education programs have been misclassified. A Puerto Rican parents group, for example, recently contracted with a local university mental health clinic to perform diagnostic tests on their children who had been classified as either "educable mentally retarded" (IQ below 80) or "trainable mentally retarded" (IQ below 60) according to state standards. The clinic found that of the twenty-one children, eleven tested in the normal intelligence range, some scoring as high as 111 on the same test the school system had used but administered by other people. Of those eleven, six children evidenced emotional disturbances that would affect their academic functioning and two were perceptually handicapped. Those ten others in the group classified as "trainable mentally retarded" all re-tested in the educable range. But six of them revealed severe emotional pathologies and two others were severely handicapped by their inability to speak English. In this particular class, all twenty-one students had been either misclassified or misdiagnosed.

BASEMENT EDUCATION

But even for those properly classified, these programs often operate discriminatorily in that differences in treatment between regular and special classes cannot be reasonably related to any sane definition of differences in educational need. In at least one district, for example, special education students are located in the basement of the school building, are required to stay down there all day, and are charged with the responsibility of opening the basement doors for late, but "normal" students who have arrived after the other entrances have been locked for the day. In another district, administrators refuse to allow emotionally disturbed children to associate at all with the other students in the building. The ban extended to building fire drills until the special teacher protested, "My kids burn just like anyone else." At that point the principal included the emotionally disturbed children in the drill but gave them a separate exit—toward the alleged fire.

Other less obvious differences in treatment are no more clearly linked to differences in educational need between regular and special students. Mental retardates, for example, are not allowed to participate in such noncognitive activities as art, music, and physical education with other children and are not eligible for speech therapy, remedial reading, enrichment programs, or Title I funding at all. Many of them have the same teacher for four or five years—thus building up, some say, either a strong antagonism or strong dependency that makes progress difficult[3]—while "regular" children get a change every year. Many are only eligible for special programs until the age of fourteen at which point the school returns them home while it retains others until eighteen at least. But the point at which any of these differences take leave of educational difference and become legally discriminatory is not entirely clear.

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[3] The fact that special education classes are nonsequential while regular classes are has a further important discriminatory effect: those children who are misclassified initially rapidly become 'mentally retarded' since they are compared year by year to children of the same chronological age who are being exposed to more and sophisticated material while they receive the same material year in year out. No amount of administrative flexibility in the classification process can correct for this problem.

WHAT CAN LAWYERS DO?

Boston poverty lawyers, aware of both the importance of moving in the special education area and the difficulty of relating school practices to educational rights and thus to legal harms, have preferred to begin under the state statutes and regulations, trying to make local programs conform to them.

Thus far they have been frustrated at every turn. The fate of administrative and statutory actions brought locally indicates something of their possibility elsewhere.

Late last June, a South End attorney began an administrative action before the state board of education under a standard administrative review provision and on behalf of a group of children who, the complaint alleged, had been punitively misclassified in special education classes. The named plaintiffs had been retested at their own expense by independent mental health clinics and found to have IQ's well above the special education class cut-off point. Furthermore since their situation was probably common to many others in the city, the complaint asked that the petition be considered a class action and that all placements be halted until the state could comprehensively review testing and placement procedures throughout the city.

Initially the state panel was enthusiastic about the case and promised the earliest possible decision. Then the situation began to erode. After months of delay, the state board quietly announced that it was limiting its decisions—which it still had not made—to the named plaintiffs and would not consider a class action. Then the city director of special education either arranged scholarships for them at private schools in the Boston area or moved them back into regular programs. That, the state board claimed, mooted the case. And there was nothing more they could do.

The primary reason for this reluctance to cooperate is the sensitive political relationship between state and local boards of education at one level and between local departments of special education and the local administrative framework which governs then at another.

State boards of education, particularly in the strongly home-rule oriented Northeast, have always trod lightly on the business of local districts. When enforcement of state regulations and statutes is left to the higher levels they prefer to leave it altogether. Special education statutes were rammed through these legislatures in the late twenties by progressive reformers who chose that level of government, not because it was peculiarly suited to monitoring local programs but because it was there that a passionately interested minority could maximize its numerically minuscule influence. The Boston administration has never shared the enthusiasm of a few Harvard wives for the educational fate of emotionally distrubed children. And the administrative boards set up at the state level to manage the provision of their "special education" could never muster either the political muscle or the manpower necessary to control the local programs.

In the meantime, the Boston Special Education Department has become the bailiwick of a particular breed of local schoolman. Some on their way up through the administrative hierarchy find their way into that department as a way station to higher positions. Others are offered jobs there as final rewards for teaching jobs well done and friends well-kept during almost finished careers. In either case, particular competence in a specialized area is not demanded and initiative is not appreciated.

Nor is the critically necessary cooperation between functionally related departments within the general administrative structure very much valued or practiced. Boston's special education department depends for its efficacy and accuracy on a separate department of testing and measurements. An MIT administrative evaluation of the managerial integration of the related areas found competition between the two departments so bitter, ill-feeling so, and communication so low that any significant interaction was non-existent. The superintendent of schools solved that problem by making the report non-existent, refusing to release it to the public. Were it not for a concentrated, highly visible, local political movement, the important issues that special education raises would also have disappeared and the administrative reform that has been promised would never have been pledged.

WHAT CAN PARENTS DO?

The impetus for that change has come primarily from those most directly affected by special education policies: those children (and their parents) who either cannot get the special treatment to which they have a right or cannot escape having the service imposed upon them when they do not need it.

Several local parents groups have surfaced in the last two years willing to publicize the results of their independent investigations of special education practices and willing to bring on-going pressure to bear on administrators responsible for them. At the least, their goal is to make those departments accountable to the most direct parties at interest. Where petitions for administrative review and proceedings under state and federal statutes and constitutions have stalled, this technique promises to bring about real reform in the Boston special education scheme.

There is increasing evidence that reform is needed everywhere. Nationwide there are fifteen times as many blacks as whites in mentally retarded classes,[4] almost certainly the result of discriminatory screening, discriminatory testing, and discriminatory placement on the part of responsible local boards. A recent detailed examination of the relationship between mental retardation and economic status concluded that the two were related in ways that discriminate against the poor.[5] And many recent testing studies are beginning to find that the incidence of so-called "psuedo-retardation" can be very high with certain commonly used instruments.

Those findings are affirmed locally in various places and various ways. Almost 30% of the students in California programs for the mentally retarded are Mexican-Americans, most of whom have had little experience with English.[6] Less than half the children established as eligible for special treatment in Louisiana have been placed. In New York, the $2000 voucher given to those brain-injured children who cannot find space in the special classes in the city is insufficient to pay the tuition at any of the city private schools. And so, as in many other cities, the children are left without any schooling at all.[7]

As they have done in Boston, poverty lawyers located elsewhere can beat their writs into community organizers as a technique for remedying some of the system's worst abuses. But there are many other, more traditional, legal avenues open and the situation is appalling enough to demand that they be explored.

First and most common to large urban areas is the case of children who would be eligible for state-mandated special programs but who are receiving no services because of inadequate space, inadequate screening programs, or insufficient funds. Where state statutes and regulations spell out criteria for these which local boards must follow but simply do not, a suit requiring conformity between practice and requirement should be helpful and fairly straightforward.

But if the language of the enabling legislation is permissive and the local district is only encouraged to maintain special programs, the individual student no longer has a statutory right to differential treatment.

Enter the state and federal constitutions. The former usually require the provision of a universal free education explicitly. And though the latter makes no reference to a right to an education, many recent commentators have made convincing cases for the idea that it is implicitly there. Under either document, anyone attempting to establish a non-statutory constitutional claim on some kind of differential school treatment must elevate the asserted but as yet unaccepted right to an education up to a right to a special education.

That would be no mean feat. But if a court accepted the argument, a series of ancillary (and entirely worthwhile) duties would fall to the local systems including: adequate universal access to the kind of tests which could identify legitimate special needs; adequate re-test provisions to check on placements; and services based not on the special classification but special need.

Absent the establishment of the necessary right to a special education, however, a claimant is left in much the same constitutional position as that of a current welfare recipient. Special education would be a matter of state largesse. The fact that a worthly individual did not receive the differentiated service would not trigger his due process rights nor would the fact that others in substantially similar educational situations received the services while he did not violate his right to equal protection.

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[4] See Arthur Jensen, "How Much Can We Boost IQ and Scholastic Achievement?" XXXIX *Harvard Education Review* 83 (Winter 1969). Jensen, of course, draws a very different conclusion from this ratio.

[5] Rodger Hurley, *Poverty and Mental Retardation: A Causal Relation* (New York: Random House, 1969). See the review in this issue.

[6] See U.H. Palomares and L.C. Johnson, "Evaluation of Mexican-American Pupils for EMR Classes," III *California Education* 42 (April 1966).

[7] See the discussion of *MacMillan v. Board of Education* in this issue.

The same would not be true of a child who had been misclassified in one of the special education categories by local administrations and misplaced in one of its programs. Without a right to an education, a student has no claim on a state benefit, but he certainly still does have standing to object to a state-imposed burden.

For him that is precisely what misplacement in a class for the mentally retarded amounts to. A normally intelligent but emotionally disturbed, perceptually handicapped, or culturally disadvantaged child assigned to an inappropriate special class suffers educationally in at least two ways. First, the school system is doing nothing about the real cause of the student's low score because it has been either misidentified or subsumed under the much broader category of mental retardation. Secondly, the level of expected performance and delivered education is less than the child is capable of. For example, Boston states its goal for special classes as "helping the child become an adjusted individual at his level of mental development in a world where he cannot excel intellectually." That description may fit for children who are genuinely retarded but for those who are not, the assumption of inferiority will limit arbitrarily the amount of education the misplaced child can get from school.

Theoretically that means the potential of the misplaced child is being developed less fully by the state than the potential of a similar child who has been appropriately placed. And humanly that guarantees degradation, humiliation, and subjection to commonly held prejudices about mental retardation without the benefit of a program responsive to real need.[8] In both cases, the classification is a state-imposed burden and, with respect to the child, irrational.

In addition the process which resulted in the misclassification is itself often irrational. Otherwise objective administrative practices may prove discriminatory in application—as is the situation when no tests are given prior to punitive placement and minority group testors are systematically excluded from administering tests. Or structural components of the process may be discriminatory in themselves—as is the case with many of the verbally weighted, middle-class scaled, English oriented "intelligence" tests used as standards in the special education area. An attack on either of these aspects of the placement process reaches back from the fact of misclassification to its causes.

To reach forward to the substance of the programs themselves, when there is no question of misclassification involved, is much more difficult. The rule of thumb is easily stated: those differences in treatment which are related to differences in educational need are at least permissible and at best constitutionally required. Those not falling into this category are impermissible and perhaps unconstitutional.

But holding a specific special education practice against that rubric won't yield clear yes or no answers in most cases. Part of the reason is that we simply don't know what techniques are effective in dealing with these "exceptional" children. There is as much controversy over the dimensions of a good program for the mentally retarded as there is over legitimate ways to deal educationally with minority groups. And part of the reason is that those factors which probably have the most to do with the success or failure of a particular special class—teacher perception and expectation, classroom atmosphere, the attitudes of the wider community—simply are not amenable to either formal definition or legalistic control.

In the meantime, of course, public school systems go right on identifying—and misidentifying—special needs according to their own best administrative lights, developing programs which they feel will be responsive to those needs, and allocating different students among them.

In that process, special education programs are only one small layer—one is always tempted to adopt current schooling metaphors and call it the 'bottom one'—in a many-layered system of differentiated programs for differentiated students. The issues involved in deciding whether to assign a third-grade student to an advanced or slow ability-grouped classroom are not much different from those involved in deciding eligibility for and placement in one of the state required special education programs. Neither are the techniques school administrations generally use for this almost universal practice or the consequences of a particular decision on the kind of education a particular 'normal' child receives.

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[8] A recent informal survey by Boston area social psychologists revealed that most employers have strong biases against hiring graduates of special education programs even though graduates performed well on those jobs they were able to find.

Current abuses in the area of special education should give lawyers pause; children with the recognized disabilities suffer most immediately. But the manner in which school systems deal with their 'exceptional' children is only a paradigm for the way they allocate their general school populations among various programs. And the disastrous outcomes raise serious questions about the ability of any administration to perform what John Gardner hails as the 'sorting process' of schools.

LITIGATION STRATEGIES: MENTALLY RETARDED MUSICAL CHAIRS

(By Em Hall)

Two recent decisions—one a New York defeat by Federal Court decree, the other a California victory by stipulation—indicate the pitfalls and promise of legal attacks on school practices in the special education area.

MacMillan v. Board of Education [Civil Action No. 3229 U.S.D.C.S.D. N.Y., July 1969] began late last July in the Second Circuit District Court as a far-reaching Constitutional assault on New York's method of financing and operating educational services for brain-injured children and ended late last month as a picayune procedural debate over the meaning of Federal rules governing intervenors and the appropriateness of convening a three-judge district court.

Plaintiffs in the original action were *three children* who had been *certified as brain-injured* under New York statutes providing for the educations of handicapped children who had *not been placed in the special classes the local Board of Education maintained because of lack of space. In lieu of services, the plaintiffs had received $2000 state vouchers.* But the amount proved insufficient to purchase the special services in private schools, where tuitions ranged from $2500 upwards, since all children certified as handicapped are eligible for the $2000 state grant, private special institutions in the city treat that as a guaranteed foundation to which they all add incremental amounts depending on the ability of their clientele to pay. As a result tuitions in these school range up to $5000. (No school charges less than $2,500, leaving those unable to raise the differential helpless.) Since all the plaintiffs were poor, it was difficult or *impossible to raise the extra money.*

That, the complaint asserted, *violated the plaintiff's constitutional right to an education, it also violated the equal protection clause in that the exercise of that right was conditioned on the wealth of those seeking to assert it.* Plaintiff's attorneys asked for the convention of a three-judge district court to hear motions for injunctive relief since, to their way of thinking, the issues were both constitutional and substantial.

In the end Judge Wyatt disagreed but it took months of procedural maneuvering to get that far. The reason: Every time attorneys put forward a brain-injured poor child who was either getting no services or was forced to make up the difference between the state voucher and the private school tuition out of his own pocket, the New York Board of Education would miraculously find a place for him in the public schools' special programs or dodge the issue on other grounds. So, while there was a defineable class, representatives of it kept disappearing into slots that hadn't been available before. Of the three original plaintiffs, one was placed in a public school program for the brain-injured, another was re-screened and found eligible for regular classes, and the last was deemed ineligible for either because he could not be safely managed.

Ento two new "similarly situated" children on motions to intervene as plaintiffs in the suit and representatives of the original class. One was immediately placed in a special program by the Board of Education; the other was re-tested and found not to be brain-injured at all. Since neither represented impoverished "brain-injured children" who had not been placed in public programs and could not afford private ones, the defendant Board of Education asserted that the interventions were inappropriate and that there was still no legitimate cause of action.

Presumably the Board of Education would have been willing to play this game of brain-injured musical chairs *ad infinitum*. But instead of placing the last intervenor, Mitchell Garlick, in a special program they re-classified him as mentally retarded and emotionally disturbed. When Judge Wyatt ruled that the relevant class under the New York statute was not only brain-injured children, but all handicapped children, the board found itself hoist by its own procedural petard and the plaintiffs found a representative for a class that everyone knew existed all along.

But that victory was short-lived, if long fought. Judge Wyatt went on to rule that the relative ability of Mitchell's family to raise the differential amount of money between the state's voucher and the private school tuition was so "obviously insubstantial" that the situation did not even warrant convening a three judge district court to hear the full claim. Education, the court ruled, was a state-distributed benefit and not something the individual child was entitled to. As such there was no issue as to Mitchell's substantive due process rights to an education. And as a public benefit the equal protection clause was satisfied so long as its distribution was numerically equal between eligible recipients. Need as a criterion, Judge Wyatt said with an exact citation to Marx, was not the "proper" and "traditional" way of distributing public benefits.

Considering the recent efforts of a series of commentators to bring education within the sphere of fundamental rights, the courts brief dismissal of the plaintiff's entitlement assertion as "obviously without merit" seems insensitive at best. But Judge Wyatt felt that the distribution of educational benefits was more analogous to subsidized subway fares, unemployment compensation, and GI benefits than it was to either the poll tax or the criminal process.

In all fairness, the case came to the court in a sufficiently complex context to scare off the most sympathetic judge. Framing the question as one of relative need confused the root issue of evacuation entitlement in at least two senses. First, Mitchell Garlick was asserting the right not to an education but to a special education, and was therefore claiming constitutional recognition of his differentiated educational needs at a time when courts are just beginning to deal with a possible right to an undifferentiated education. Secondly, Mitchell wasn't being denied a special education; his family merely had to make a greater effort to purchase it than did other families with greater financial resources. The Garlick family had a weekly income of $130; Mitchell's mother could have made up the difference between the state allotment and the private school tuition. Judge Wyatt was understandably reluctant to get the court into the business of saying how hard she would have to work as a matter of law to do that or what other sacrifices she should make to get her child into school.

But after subtracting the family's particular financial situation and Mitchell's special educational needs, there remains the underlying notion that he was entitled to some minimal educational service, as a matter of constitutional right. If he had been receiving no education at all—as is the case with many handicapped children—*or if there had been no tuition voucher scheme designed to allow him to purchase alternative services—as is the situation in many less progressive states than New York—the preliminary and fundamental issue of educational entitlement could have been posed directly.*

That notion, as Judge Wyatt pointed out, represents a radical departure from traditional constitutional theory. But it is a necessary (if not sufficient) first step in reaching the obviously burdensome situation Mrs. Garlick found herself in. As such it must be presented in its clearest factual light to gain some real chance of acceptance.

Once uncabined, educational entitlement will reorient the impossible questions of relative need and deprivation that so troubled the court in *MacMillan*, reformulate such problems as the difference between state grants and private tuitions, and allow judicially manageable standards to re-surface. If Mitchell Garlick had been entitled to publicly provided special education services and the New York Board of Education had refused to provide it on the grounds of lack of space, then the state would have been obligated to pay at least the full tuition at the least expensive school offering minimally acceptable similar programs. The complaint's gravamen would become the service and not the tuition; the test of tuition would not be relative individual need but sufficient money to purchase alternative services in the private sector; and that issue, involving as it does community standards, could be resolved by a court.

CALIFORNIA SUIT

Diana v. State Board of Education [C-70 37 RFP, Dist. Ct. No. California, Feb. 1970] chose a different standard approach to the worst abuses in the California special education scheme. But the suit's aim was not so much to get children with appropriate needs into appropriate programs as to keep children from being misplaced in inappropriate programs. The attack naturally focussed on classification standards rather than the educational needs of particular students.

That meant the tests on the basis of which California school boards designated certain children as "educable mentally retarded" and placed them in special classes whose aim was "to make them (the children) economically useful and socially adjusted," and no more. Plaintiffs in the suit were all Mexican-Americans, for the most part children of poor farm workers, who had scored below the cut-off point on Stanford-Binet and WISC tests and so had either been located in special classes or were about to be placed pending administrative action by the local board.

The complaint recited a catalog of objections to the use of these tests on these particular children: a heavy emphasis on English verbal skills which discriminated against Spanish-speaking students because the language of both the test and the testor was unfamiliar; a built-in cultural bias in the verbal sections which posed vocabulary questions in such a way as to favor children with middle-class experience (the test asked about the color of rubies, not plums; about umbrellas, not sombreros; and demanded a response to "Why is it better to pay bills by check than cash?"); an IQ score standard that was invalid for children who had already been misplaced in special education programs since it involved comparing the mental age of the testee to his chronological age when the mentally retarded class was not sequential in the same way that regular programs were; and a discriminatory standardization of the scores and items of both tests in that they were based on a sample population made up entirely of white, native-born Americans.

As proof of the effect of these various biases plaintiffs offered the fact that while Mexican-American children made up 13% of the California school population, they accounted for almost 30% of special education students within the state. When the nine named plaintiffs were re-tested with the same instruments by bilingual psychologists who allowed responses in either langugage, seven scored an average of ten points above the state-mandated cut-off point and the other two hovered around the line where before their scores had ranged from 30 (an IQ so low the child would have been unable to care for himself) to 63. Furthermore, when the mental age of the plaintiffs was compared not to those of a similar age in regular programs but to those two years younger who had been exposed to roughly the same opportunity to learn as had the special education children, all of them produced scores again above the cut-off point. Finally, when the results of the verbal and non-verbal sections of the tests were treated separately so that the effect of language differentials was minimized, plaintiff children again revealed scores at least fifteen points above their verbal scores and again well above the special education cut-off. Tests that purported to measure mental intelligence clearly measured something else, to the detriment of the Mexican-American students.

To remedy the situation the plaintiffs asked for a variety of significant reforms. All children from non-English-speaking homes could only be tested in both their primary language and English, the tests to include only those questions which did not depend on vocabulary, general cultural information, and verbal questions unfamiliar to the normal minority child. In the meantime, California state psychologists would be required to re-norm a new or revised IQ test whose items would reflect Mexican-American culture and whose scores would reflect comparisons to the performance of minority peers and not the population as a whole. For those local districts where the population of the special classes indicated significant misclassifications—defined as any district where the percentage of Mexican-Americans in those programs was greater than the percentage in the general school population—all so-called mentally retarded students would receive re-tests in their primary language, the scores of which would be based solely on their non-verbal, performance components. Where misplacements were unearthed, the state board of education would begin and continue to monitor special supplemental programs designed to reintegrate the misclassified student into the regular curriculum.

When the Californboard ia decided to settle the suit by stipulated agreement with the plaintiff's attorneys, the possibility of discovering how far a federal court might go in expressing judicial interest in the extremely controversial area of psychological testing was foreclosed, as was the question of whether even the most sympathetic court would find itself institutionally equipped to order the significant institutional reforms the Mexican-American children asked for. In the end the board of education acceded to all of their demands and even accepted as formal state regulations a new draft of the special education code re-written by the plaintiffs. But the precise course courts will take, faced with similar fact situations and more recalcitrant defendants, remains ambiguous.

So too do the precise legal implications of a multi-faceted and often ambiguous complaint going to the heart of the technique most school administrations use to justify (if not objectify) decisions as to which students will get what kind of education. It is never clear from the complaint, for example, whether the primary focus is on the way tests measure what they measure or on the narrow range of skills they measure. Re-standardizing test scores on the basis of a minority group population promises more apparent than real reform; re-norming the tests on the basis of minority culture may only correct the most flagrant abuses in their use. A Spanish-speaking child is aided obviously and immeasurably by examinations given in his native language and drawing on items familiar to his experience. But is it any real help to tell a child who runs the hundred-yard dash in 14 seconds that his is the fastest time when white middle class students continue to run it in ten and when his real strength is high jumping?

Nor is it possible to predict the receptiveness of a court to similar testing claims on behalf of a different and more inclusive minority group. Language is only the most obvious cultural difference that may skew the extremely sensitive relationships between testor, testee, and test instrument. Even though the research is far from conclusive, racial mismatches, class mismatches, and testor-testee mismatches have surfaced as critical components in ordering the relative influence of these three in the production of certain test results with certain children.

For the forseeable future courts will hesitate to sort out this polycentric mess in the framework of constitutional law. Stipulated agreements, where they are politically feasible, can be flexible enough to respond to the real complexities of the testing situation. But it is at least possible that the focus of court attacks on the tests themselves is mis-directed.

The problem may be not the instruments but their uses, not the tests, but their administrators. If that is so, a transfer of the power to use intelligence tests in placing children in special education programs may prove to be a legal remedy more responsive to the abuses they lend themselves to than any reformulation of them—to say nothing of the fact that the language of masters and receiverships is much more familiar to the courts than the language of statistical test standardization.

The testing movement grew as a way of providing objective checks against the bias of teachers who made educational decisions about children on the basis of personal convenience. Current abuses in the use of intelligence tests can now be seen as serving the personal exigencies of the school institution: Children who are difficult to deal with educationally are shunted off into classes for the mentally retarded where no education is expected.

Tests are used to justify this process but responsible use of them would never permit this result. After all abuses in the current system have been exposed through the use of new testors and not new tests. To do away with them altogether would throw school systems back on the days when instructors did what they pleased with minority children—with worse results than today. And to pretend that different children did not have very different educational needs—which properly used tests can help to identiy—would throw the institutions forward to that chimerical liberal empyrean where all children would be the same before God and the elementary school principal. Where systematic discrimination can be shown and where that discrimination threatens important constitutional rights—as it certainly has in California, Boston, New York, and New Orleans—then a more educationally appropriate remedy might be an injunction against the further institutional administration of intelligence tests and a requirement that the school system contract its testing services to independent mental health clinics approved by the court.

In the meantime, the relative success of *Diana* and the relative failure of *MacMillan* indicates that for some time it will be easier to attack existing special education standards than to delineate individual special needs and simpler to police existing programs than to create new ones through the courts. Those who feel the urge to shake the tail of the special education universe can take consolation in the fact that, at these beginning stages, even the most straightforward legal action will produce badly needed educational movement.

Life Retardation: A Review

POVERTY AND MENTAL RETARDATION: A CAUSAL RELATION

(By Rodger Hurley, New York: Random House, 1969)

Mental retardation, Rodger Hurley argues in this study, is not so much the result of genetic happenstance as it is a cultural imposition, one that weighs most heavily on the poor. Mental retardation is, in short, an outcome of the bad food, bad health, bad education, bad jobs, bad housing, and all the rest that are the special burdens of the poor.

The book, an exhaustive collection of observations and studies made over the last half century, is most persuasive. Each report is briefly summarized and fully cited, making it easy for readers to pursue more fully any particular aspect of life retardation that interests or concerns him.

There is much collecting and little analysis here. In virtually swamping its readers in facts and statistics, *Poverty and Mental Retardation* becomes a moving declaration of the tragic consequences of social indifference.

For the lawyer representing the poor, this book should be a first source of social-science evidence on the consequences of neglect. Is it unequal access to housing, exorbitant medical fees, job discrimination, or delivery of public services that is being attacked in litigation? No matter what aspect of discrimination is being challenged, *Poverty and Mental Retardation* summarizes the appropriate studies in a form ideally suited to the needs of the advocate of the rights of the poor.

This is particularly true with respect to questions of educational neglect. That all children are entitled to something called a public education is so generally accepted that only constitutional lawyers doubt it. That poor children suffer from the debilitating effects of crowded classrooms, inferior teachers, and fewer dollars; that this suffering is reflected in consistently low scores on almost any measure of educational achievement; this is less well understood. That this general process which holds back poor children is also reflected in many school systems in classes for the mentally retarded being overpopulated by poor and black children is hardly understood at all. Hurley's description of the treatment accorded those children who have been labelled retarded or uneducable by their schools is particularly pointed. Consider his description of a "showcase" treatment center:

> ". . . it is severely overcrowded; it houses children ranging from murderers to those who are the victims of badly broken homes. All who can fit live in tiny cells; the others live together on temporary cots in a large room. *No education is provided for the children;* the only recreation area is a patch of black top completely enclosed by screening. No child is allowed out of doors . . ."
>
> [page 177; emphasis added]

Such treatment makes a mockery of the educational entitlement that these children—indeed, all children—are guaranteed by the fourteenth amendment and by state constitutions which provide for a universal system of free common schools. It is a source of great concern to parents and educators; it demands challenges, through test litigation and other representation, from the legal advocates for the poor.

Hurley provides the statistics and the studies; in doing so he performs an absolutely necessary service. What he has not done—and what badly needs doing—is to marshall these statistics and studies in a coherent fashion, to argue from this disparate array of information to a social policy aimed at eliminating these outrages. What is called for is a set of recommendations that directly address the social problems that lead to mental retardation and secure for the poor child and his family a level of services—dollars, jobs, education, health—that will enable them to do more than merely survive. At present, as *Poverty and Mental Retardation* makes abundantly clear, survival is for the poor a remarkable feat; but this is hardly a cause for social self-congratulation; it is a call for direct and extensive social action. Certainly litigation in these areas is only a beginning, but that is precisely what we need to do: to begin.

David L. Kirp.

A Bibliographical Note: Reading on Mental Testing and Retardation for Lawyers and Other Laymen

People who get exercised about special education have always tended to work out their rage on a typewriter instead of on the local school board. No educational area has been so over-researched and under-reformed. Among the literally thousands of books, studies, and articles dealing with the subject, the following may prove to be of particular help to lawyers interested in moving against the worst abuses in the current system:

Milton Schwebel, ***Who Can Be Educated?*** (New York: Grove Press, 1969). The dean of the Rutgers Graduate School of Education takes a lengthy and informed look at the way school systems decide which children get what kind of education—including special services—and finds the whole process wanting. His culprit: IQ tests. The book is long on passion, short on scientific documentation, and shorter still on viable reforms; it is primarily useful as an overview and as a catalyst to further investigation.

Ann Anastasi, ***Essentials of Psychological Testing*** (New York: Harper and Row, third edition, 1969). This is the most readable reference work in the complicated but critical field of educational testing. The book includes chapters on all different kinds of tests, including discussions of their purposes, construction, validity for different segments of the population, and appropriate use. The book is easily comprehensible to the layman and provides him with the necessary groundwork for talking to professionals in the field.

Note, "The Legal Implications of the Use of Standardized Ability Tests in Employment and Education," (68 *Columbia Law Review* 691, April 1968). This note deals more extensively with discriminatory employment tests than with educational ones. Nonetheless, this highly controversial article represents a pioneering effort at relating test construction and administration to constitutional and statutory prohibitions against racial discrimination. It is an advocate's brief, but very useful to lawyers.

Testimony of Doctor Roger T. Lennon as expert witness on psychological testing (New York; Harcourt, Brace and World, 1967). Dr. Lennon, the chief test maker for one of New York's largest publishing firms, has his day in court defending the use of ability and intelligence tests in the Washington, D.C., school system as a defense witness, and then submits to the cross-examination of William Kunstler. The case, ***Hobson v. Hansen***, resulted in a victory for the plaintiffs and is the only court decision so far in which the tests themselves have been found to be discriminatory. The book, which includes all direct and cross examination of Lennon, will be helpful to litigators interested in testing for the sense it gives of the direction court testimony is likely to take and the issues that are likely to be raised.

Sylvia Richardson and Jerrold Normanly, "The Incidence of Pseudo-retardation in a Clinic Population," (109 *American Journal of Diseases of Children* 432, 1965). This is one of many reports on investigations of the misclassification of children who appear to be mentally retarded but who are not in fact. The authors argue that certain tests guarantee such misdiagnosis and go on to suggest ways to avoid the problem through use of other, more evaluative and less predictive testing instruments. The population under study was unique, but the discussion of how to compensate for testing errors applies generally and will prove particularly useful in devising remedies in litigation.

Note, "Education of Exceptional Children," (XXXVI *Review of Educational Research* February 1966).

Note, "Educational and Psychological Testing," (XXXVIII *Review of Educational Research* February 1968).

[WESTERN UNION TELEGRAM]

JULY 14, 1969.

To: MEMBERS OF SENATE D.C. SUBCOMMITTEE OF THE APPROPRIATIONS COMMITTEE.

The more than thirty D.C. member agencies of Concerned Citizens for Exceptional Children unanimously urge your restoration of the $1.2 million cut from the Board of Education's request for Department of Special Education FY-70 funds. This cut was made from the school budget by D.C. Budget Office prior to submission of budget to the D.C. City Council.

PRIORITIES IN RESTORATION OF FUNDS CUT

Sen. Pearson on June 16 requested a list of priorities in restoration of D.C. funds previously cut. We support following order of priorities in restoration of $1.2 million special education funds cut:

1. $500,000—Tuition aid for handicapped, previously cut by D.C. Budget Office from $600,000 to $100,000.

2. $96,757—For Developmental Center, cut entirely.
3. $168,000—Education Centers for Emotionally Disturbed Children, cut from $336,000.
4. $60,000—Salary for teachers for children with learning disabilities.
5. $3,000—Special Pre-Kindergarten Program for handicapped children.
6. Balance—Other Special Education Programs.

THE NEED

This critical need is reflected by the fact that (1) in school year 1967–68, funds were available for Department of Special Education to serve less than 10 per cent of the estimated 17,000 to 22,000 handicapped school age children of D.C.; (2) the 11 to 15 per cent of the total school population who are handicapped are scheduled to receive through the Department of Special Education only 3.95 per cent of the total schools FY–70 OPTG budget to serve their needs; and (3) the restoration of the $1.2 million previously cut can only be a start toward their proper education, since the National Education Association estimates that the handicapped child requires two to three times the appropriation of the normal child to adequately serve his needs. However, this $1.2 million is critical because of the programs it affects.

ECONOMIC IMPACT ON D.C.

The economic impact on D.C. of educating, or not educating, the handicapped D.C. school age children is great. Proper education now in special education classes of the more than 15,000 handicapped D.C. children who went unserved in school year 1967–68 would bring a massive infusion of income into the D.C. area in future years. Eighty-five per cent of the handicapped, according to national associations, can be made productive with proper education and vocational training. Eighty-five per cent of this 15,000 made productive, would bring into the D.C. area, year after year, at least $40 million annually if each handicapped worked at only the minimum wage of $3300 a year. This would bring in over $4.4 million in Federal income taxes paid on that salary. D.C. needs the income and taxes these handicapped could produce.

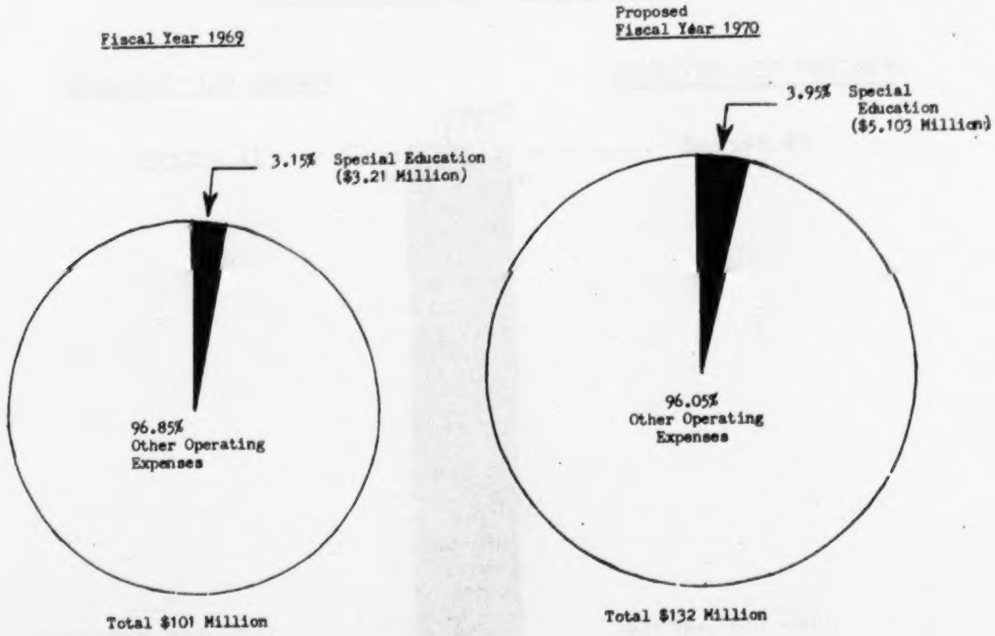
On the other hand, if we fail to educate this 15,000 now, they are destined to become (1) institutional care cases at an average of $100,000 each in lifetime Federal costs, or (2) welfare cases at an average of $44,000 to $100,000 lifetime Federal costs, or (3) become non-income producing dropouts and further economic burdens to the D.C. area.

THE CHOICE

The choice, then, is clear. Educate these handicapped children and make them productive, self-respecting, income-producing citizens, instead of future Federal tax burdens on society. Your restoration of the $1.2 million cut can make a good start in their rehabilitation. We urge this action and know that the D.C. Board of Education will support you.

James W. McCord, Jr.,
Chairman, *Concerned Citizens for Exceptional Children.*

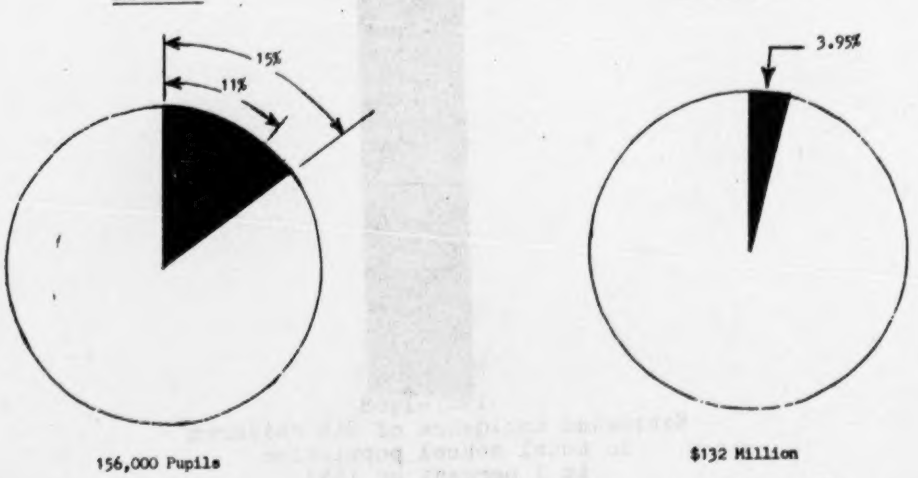
SHARE OF D. C. PUBLIC SCHOOLS' OPERATING BUDGET ALLOCATED TO SPECIAL EDUCATION



Source: D. C. Mayor's Budget Proposal for FY 1970

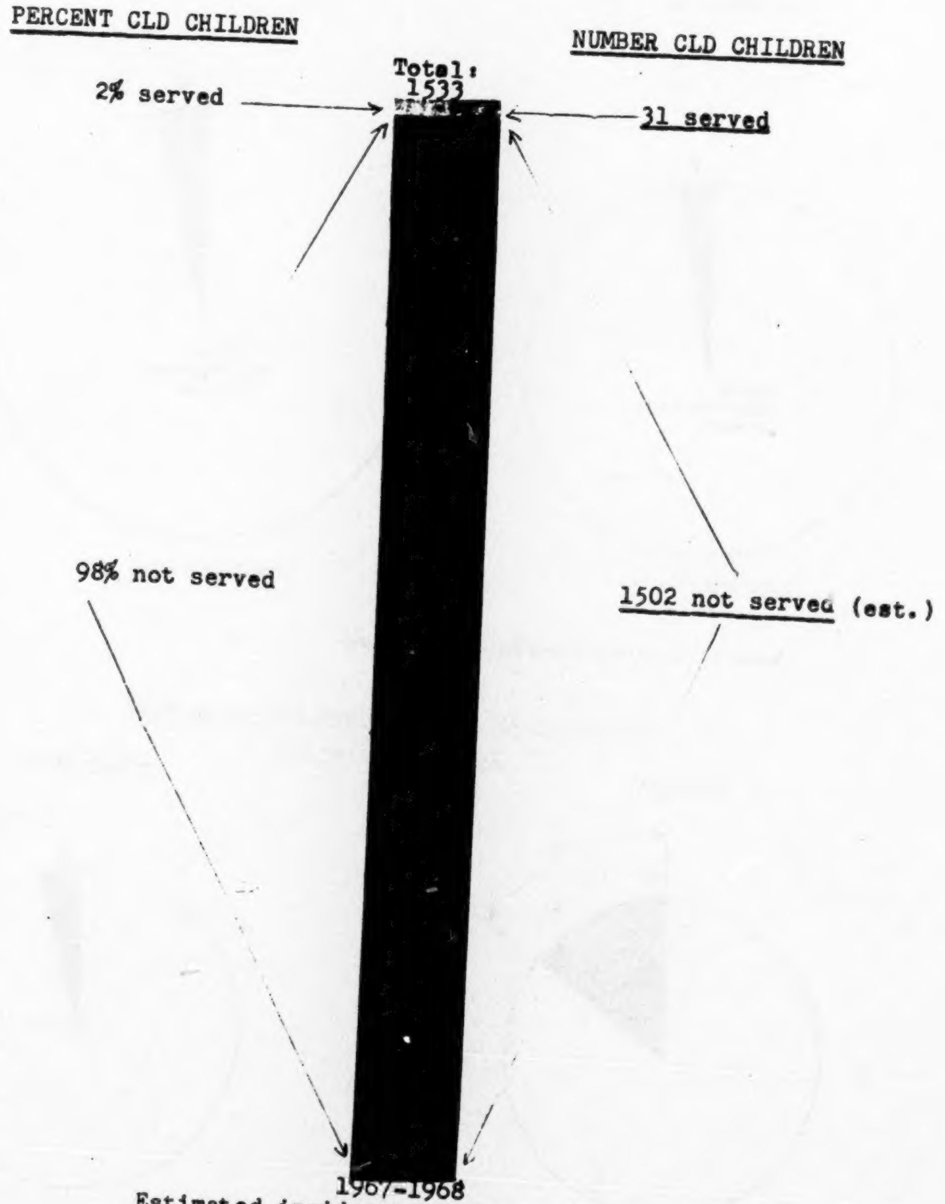
SPECIAL EDUCATION'S SHARE OF ENROLLMENT AND OPERATING BUDGET

Proposed Fiscal Year 1970



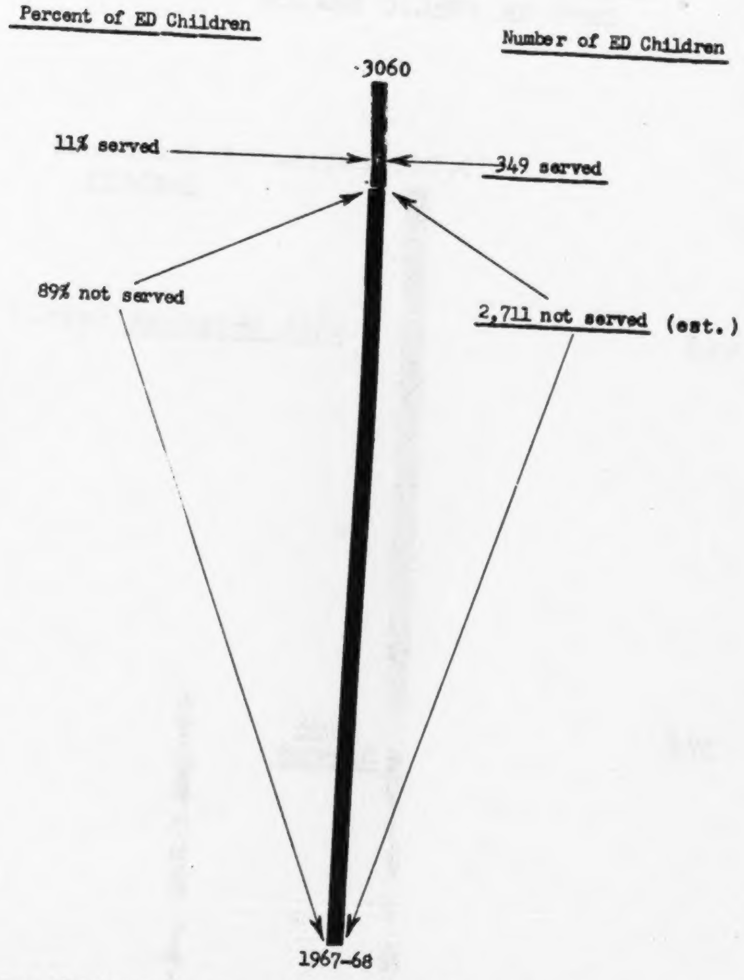
Source: Mayor's Proposed FY 1970 Budget

CLD (SLD)
CHILDREN WITH LEARNING DISABILITIES
(SPECIAL LEARNING DISABILITIES)



Estimated incidence of CLD children
in total school population
is 1 percent or 1533
of these 1533 children, only 31 were served in 1967-1968
Sources: HEW January 1969 incidence rates
D.C. Schools Annual Report 1967-1968

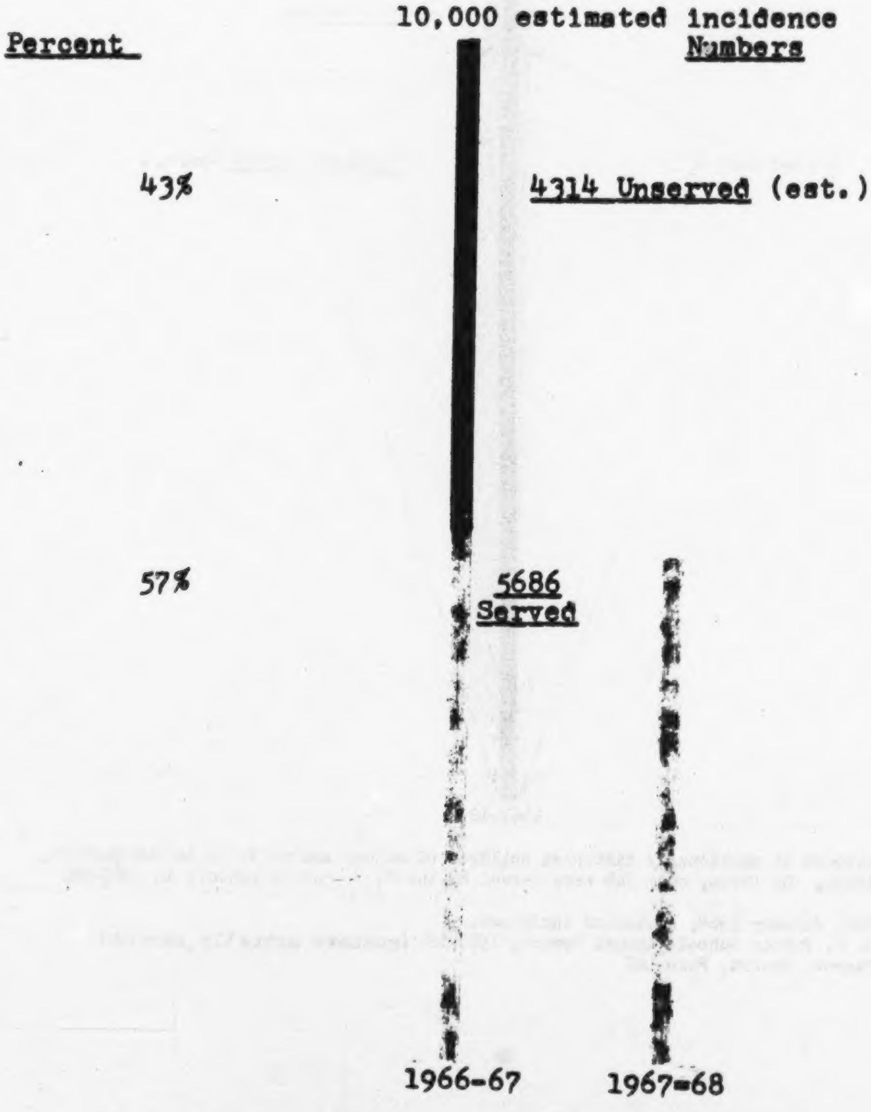
EMOTIONALLY DISTURBED CHILDREN



Estimated incidence of emotionally disturbed children of school age in D. C. is two percent, or 3,060 children. Of these, only 349 were served by the D. C. public schools in 1967-68.

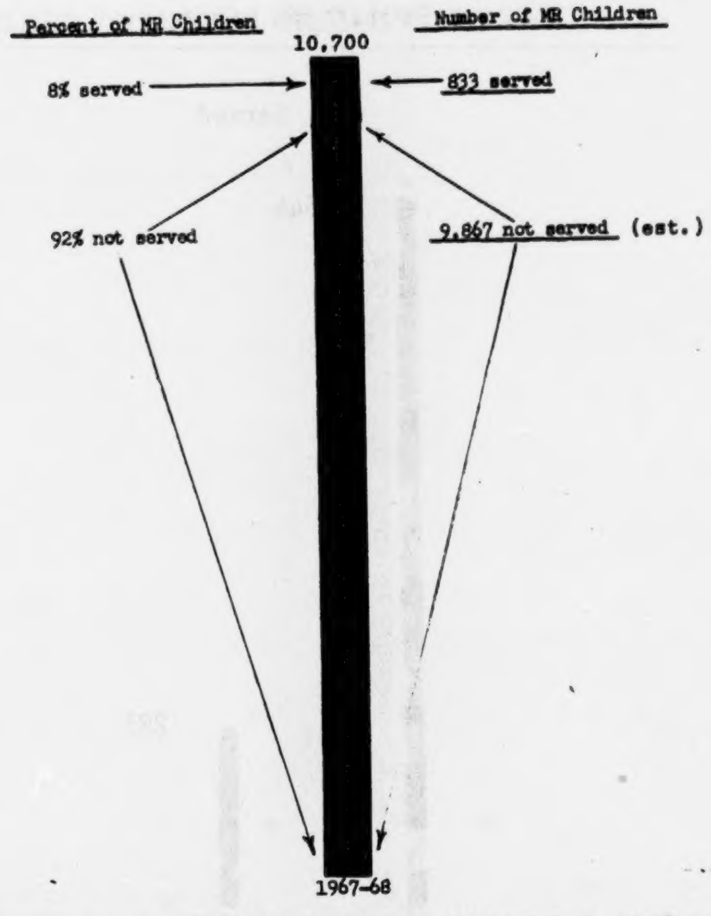
SOURCES:
1. HEW, January 1969, estimated incidence.
2. D. C. Public Schools Annual Report, 1967-68 (numbers actually served)
3. Passow Report, Page 467

Speech and Hearing Impaired
SERVED BY DISTRICT OF COLUMBIA
DEPT OF PUBLIC HEALTH



Source: Passow Study, Page 405
Estimates of served and unserved are from the D. C. Department of Public Health as reported in the Passow Study.

MENTALLY RETARDED CHILDREN



Estimated incidence of mentally retarded children in the total D. C. school population is seven percent, or 10,700 children. Of these 10,700, only 833 were served in 1967-68 in special education programs (486 trainable children, 347 educable).

SOURCES: 1. President's Committee on Mental Retardation — Inner-City Incidence, 7%
2. Passow Report, Page 405
3. D. C. Schools Annual Report, 1967-68 (numbers of retarded actually served

JACKET NO. 75-590 OFFSET ILLUS. No. 8a

Width 26½, Depth 31 | 58 % (FOCUS)

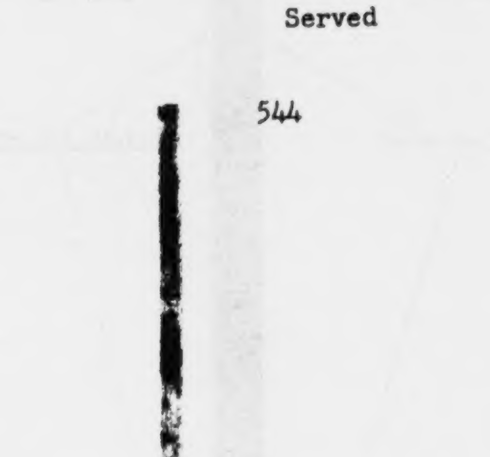
☐ Sq. Ht. ☒ Line ☐ Broad ☐ Poster

☐ Duo Tone ☐ Rescreen

Add'l. Info:

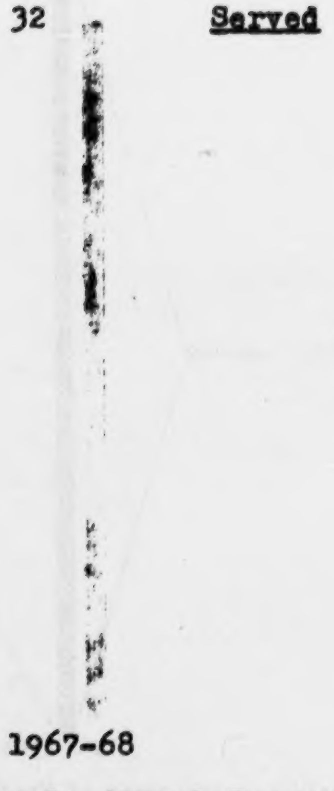
VISITING SPECIAL EDUCATION INSTRUCTION

HOMEBOUND AND HOSPITALIZED HANDICAPPED CHILDREN



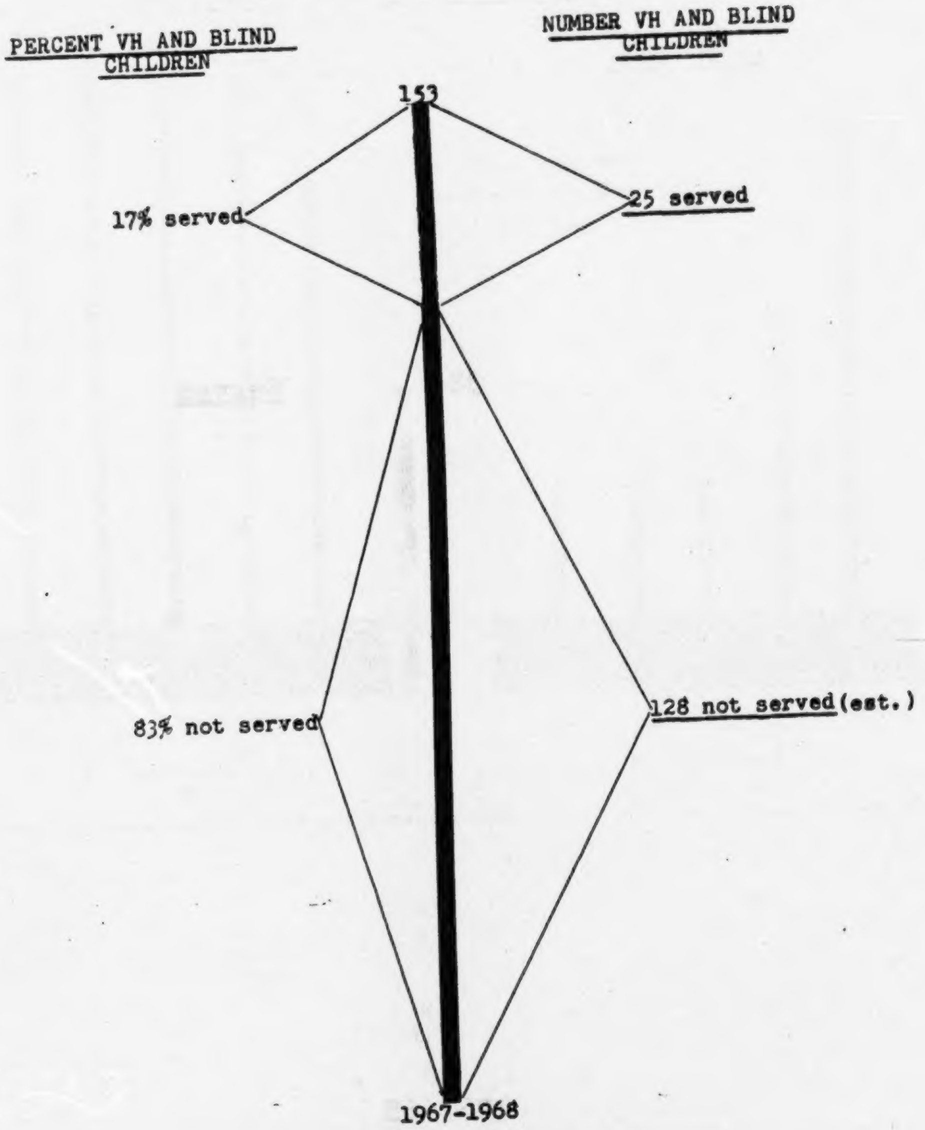
Source: (1) Passow Report, page 455.
(2) D. C. School's Annual Report, 1967-68.

Hearing Conservation



Sources: D.C. Schools Annual Report 1967-68

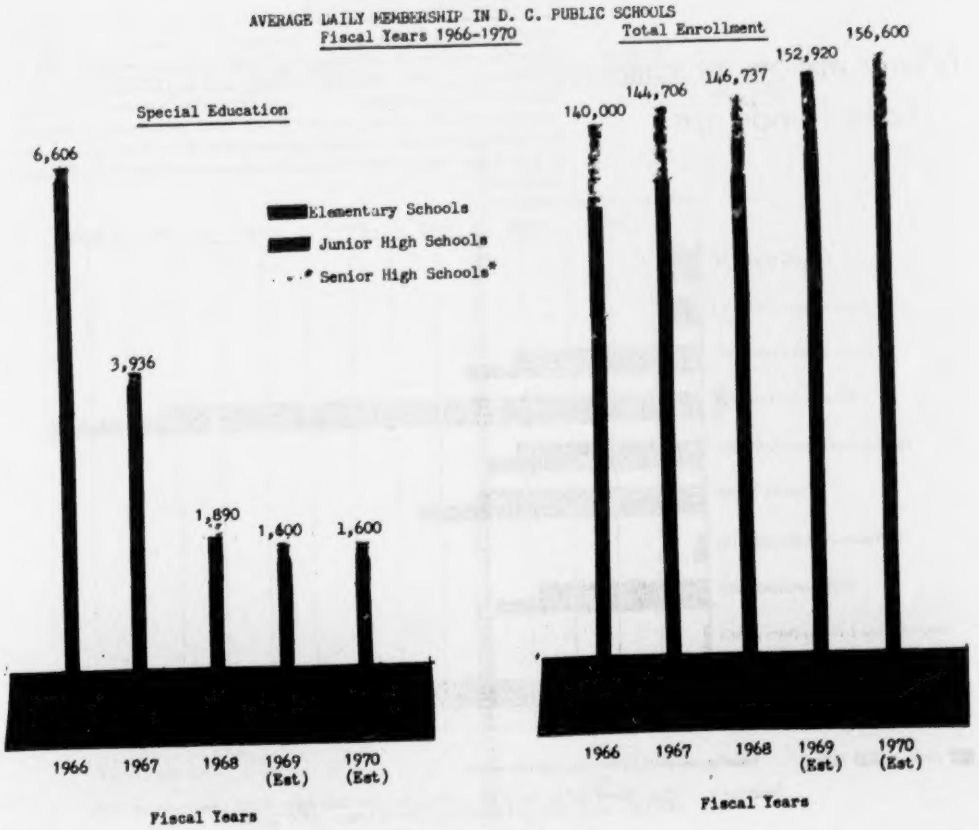
VISUALLY HANDICAPPED AND BLIND



Estimated incidence of Visually Handicapped
and Blind Children
in total school population
is .1 percent or 153
of these 153 children, only 25 were served in 1967-1968

Sources: HEW January 1969 incidence rates
D.C. Schools Annual Report 1967-1968

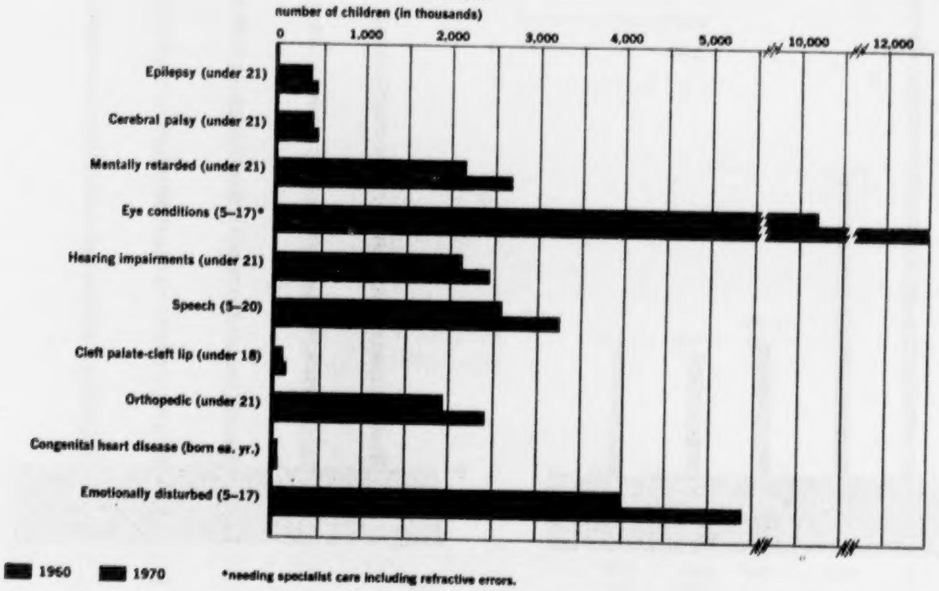
AVERAGE DAILY MEMBERSHIP IN D. C. PUBLIC SCHOOLS
Fiscal Years 1966-1970



Source: D. C. Mayor's budget proposal for FY-70, Oct. 1, 1968
*Includes vocational high schools and Americanization and Capitol Page School, in chart showing total enrollment.

Many millions of children have handicaps.

Precise figures are not available on how many handicapped children there are in this country. From a review of surveys of various sizes and some variation in definitions, the Children's Bureau has estimated the prevalence of certain conditions in 1960, and in 1970 should levels of incidence continue unchanged. The figures shown are indicative of the large numbers of children in our population who have handicapping conditions. By education standards, it is usually estimated that about 12 percent of children of school age are in need of special education because of handicapping conditions.



*needing specialist care including refractive errors.

Source: "The Nation's Youth", Childrens Bureau Publication # 460, Social and Rehabiliation Service, HEW 1968

WHO ARE THE MENTALLY RETARDED?

(By Gunnar Dybwad)

Gunnar Dybwad has been professor of human development, The Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, since February 1967. Previously, he was for 3 years director of the mental retardation project of the International Union for Child Welfare, Geneva. From 1957 to 1963 he was executive director of the National Association for Retarded Children, and in 1963 also served as a consultant to the White House on mental retardation.

Not only in the United States but in many countries around the world, there is today an unprecedented interest in the welfare of mentally retarded children and adults. Whole new systems of services to aid them and their families are being developed, supported by extensive governmental and private efforts. A vast literature has appeared during the past 10 years. Millions are being spent on research and demonstration projects.

Yet, one encounters with increasing frequency the questions: Who exactly are the mentally retarded? Where are they? How many are there? The suggestion has even been seriously made that there is no such thing as mental retardation. Those who make it point out that as the term *mental retardation* covers a multitude of widely divergent conditions, resulting from separate biological or cultural origins and manifesting themselves in different, unrelated forms, there is no logical basis for a collective designation.

For a good many years, similar arguments have been raised against the term *mental illness*, which also covers a large conglomeration of conditions of diverse origin.

NOTE.—Based on a paper presented at the Summer Institute on Social Work in the Rehabilitation of Mentally Retarded Persons, Columbia University, July 17, 1967.

I cannot subscribe to such a view. It seems to me that for the daily practice of persons engaged in rehabilitation, health, and welfare services both these terms are useful. I am willing to concede that there may be some validity for speaking of mental illnesses rather than mental illness and also for using some plural forms for the collective terms *epilepsy, cerebral palsy,* and *mental retardation.* Yet we have traditionally used the singular in a plural sense without any real problems in communication.

A different position would have to be taken by physicians, biochemists, and other biological scientists concerned with specific diagnostic and therapeutic considerations. But when a discussion is focused on the social manifestations of retardation and the social measures needing consideration, I think we can find a sufficiently firm point of departure in the concept of mental retardation defined as *significantly subaverage intellectual functioning, manifested during the development period, and associated with distinct impairment in adaptive behaviors.*

This is the definition of the American Association on Mental Deficiency with the addition of two qualifying adjectives. I have modified "subaverage" with the word *significantly*, as suggested by John Kidd,[1] and "impairment in adaptive behaviors" with the word *distinct.* This modification conveys disagreement with the view of those who are inclined to extend the concept of mental retardation to cover relatively minor deviation from the norm. Both from the point of view of the persons so characterized and from the point of view of effective administration and practice, a more circumscribed concept is preferable, one that would exclude the broad and confusing area termed "borderline."

In 1953, an expert committee of the World Health Organization suggested for international usage the term *mental subnormality*, subdivided into two categories: *mental deficiency* for cases of biological origin, and *mental retardation* for cases of sociocultural origin. Even though this proposal was a focal point of a widely distributed pamphlet published in 1954 and entitled "The Mentally Subnormal Child," [2] this terminology has not been accepted, and the World Health Organization today is using the general term *mental retardation* in its official documents.

Where does this leave us as far as the boundaries of mental retardation is concerned? In the past, the likely answer to this question would have been that an IQ rating of 70 or 75 on a standard intelligence test would constitute the upper boundary. But today one would have to answer the question differently, saying that in general the term *mentally retarded* does not usually apply to anyone with an intelligence score above 70 or 75 but by no means includes all with lower scores, and in exceptional cases may apply to persons who score higher. Whether or not a person should be designated as mentally retarded depends not just on measured intelligence but also on the second criterion in our definition of mental retardation: *a distinct impairment of adaptive behavior of the social performance in day-to-day living normally expected from a person of a particular age by the community (or culture) of which he is a part.*

Thus a man who scores 65 on an intelligence test and who at the same time shows himself well able to adapt to the social demands of his particular environment at home, at work, and in the community should not be considered retarded. Indeed, we now know that he is not generally so considered. This is why large-scale attempts to identify the mentally retarded in a given community always end up with a far smaller number of persons than had been predicted from the expected distribution of intelligence.

However, in spite of growing acceptance of this second criterion, "social adaptation," attempts at quantifying it through measures similar to the various intelligence tests have thus far failed. This is why at this time it is impossible to give a clear answer to the question, "Who are the mentally retarded and how many are there?" It seems clear, nevertheless, that the still widely made statement that 3 percent of the population are mentally retarded is no longer tenable.

PREVALENCE AND DEGREES

But what *do* we know about the prevalence of mental retardation? We know that in the so-called developed countries between 1 and 2 percent of the population—in other words, one to two persons per thousand—are so retarded as to require residential care under present circumstances.

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[1] Kidd, J. W.: Toward a more precise definition of mental retardation. *Mental Retardation*, August 1964.

[2] World Health Organization: The mentally subnormal child: report of a joint expert committee convened by WHO, with the participation of United Nations, ILO, and UNESCO. WHO Technical Report Series No. 75, Geneva. April 1954.

With a somewhat lesser degree of certainty, it can be said that in the developed countries between 3.5 and 4.5 persons per thousand would score below 50 on an intelligence test.

In looking at these two figures, it is important to recognize that the first, of one to two persons per thousand in need of residential care, includes a large number of persons who could score above 50 on intelligence tests but are markedly impaired in social adaptation.

Attempts to get a true estimate of how many mentally retarded persons there are outside these two categories have thus far resulted in widely varying figures—the lowest ones coming from the Scandinavian countries. Cultural factors and educational policies seem to play a major role in this regard. We must today admit that we know far less than we *thought* we knew 5 or 10 years ago!

But what about the qualitative aspect of mental retardation? What can be said about different degrees of retardation among the mentally retarded? Here, too, we find that our knowledge is far less definitive than we once thought. Twenty years ago, anybody who had taken a course in psychology "knew" that the mentally retarded consisted of morons, imbeciles, and idiots and that these terms were defined by IQ scores from 50 to 70 or 75 in the first instance, from 25 to 49 in the second, and from 0 to 24 in the third. Later, as increasing opposition was expressed in regard to these particular terms, "mild," "moderate," and "severe" were substituted as more appropriate and were adopted by the WHO in its 1954 reports.[2]

It was a happy state of affairs for those of us involved in decisions about mentally retarded persons. All we needed was a psychometrician to provide an IQ score for our subject and, presto, we not only knew to which of the three levels of mental retardation to assign him, we also could find out from charts in textbooks just what could be expected of him. And since IQ's were believed to be fixed, that was that.

But then came disturbing new discoveries. First, IQ's as an expression of a person's intellectual functioning were found to be subject to distinct changes if conditions in his life changed to a sufficient degree. And second, social adaptation was found to be a crucial factor, along with measured intelligence, in judging the degree of a person's mental retardation.

And how has practice in health, welfare, and rehabilitation agencies responded to these discoveries? Quite remarkably, it seems to me, by ignoring them and continuing to use the old convenient terms and basing judgments almost entirely on the measured IQ

AREAS OF CONFUSION

Educational practice has unfortunately confused the situation even more.

In the 1950's educators in our country commendably sought to widen school programs for the mentally retarded beyond the classes existing for the mildly retarded. They believed that persons of less intellectual endowment than those admitted to these special classes required quite different methods of teaching. They therefore made a distinction between the kind of programs to be provided for mildly retarded persons whom they regarded as capable of profiting from an "educational" process and for the moderately retarded whom they regarded as capable of being "trained" only to do the simplest tasks, incapable of rational thinking, and unable to acquire any kind of academic skill. Hence the terms "educable" and "trainable" came into use.

Unfortunately, shoddy thinking brought about a perversion in the use of these terms. Originally they described two types of schooling, but nobody had suggested that *all* children with IQ's between 25 and 49 would be capable of profitably attending classes at the "trainable" level. Yet, by and by, more and more workers and writers in the field of mental retradation simply referred to *all* children with IQ's between 25 and 49 as "trainable." The result, of course, was that some "trainable" children have been found by the schools to be untrainable, that is, inadmissible to the classes. Still worse, some workers refer to postschool young people and adults as "educable" or "trainable" even though no sheltered workshop has ever found performance in an "educable" or a "trainable" class to be a reliable predictor of performance in the workshop, where quite different kinds of skill are demanded under quite different circumstances.

Another remnant from the period when a person's intelligence was regarded as static is an unfortunate misunderstanding of the psychological concept "mental age." Intelligence tests consist of a succession of subtests corresponding to the performance that can be expected from the average child of a specific age. It is all right to say that a certain 20-year-old person scored on a certain part of an intelligence test only as high as could be expected of a 3-year-old child. It is a questionable practice, however, to combine this 20-year-old person's ratings on various parts of the test and say that he scored the same as would be expected of a 3½-year-old child when what actually happened is that on some parts of of the test he scored as low as a 2-year-old and on others as high as a 6-year-old.

Most people do not keep in mind that the term "mental age" refers to the result of a mathematical averaging of a large number of scores on test items. This leads to the further misconception that a 20-year-old man with a "mental age" of 3½ is *like* a child of 3½ and therefore should be treated like such a child.

This is, of course, *disastrous nonsense*. There are no 3½-year-old children who are 5 feet 7 inches tall and weigh 160 pounds, who have had 20 years of some kind of social experience, who have mature sexual organs, and who have the strength to stand for several hours lifting heavy logs onto a truck. Mentally retarded persons are *not* "eternal children," and this sentimental way of referring to them is an insult to their dignity as human beings.

CONFUSIONS ABOUT PROGNOSIS

Another point needs to be emphasized. Mental retardation is not infrequently associated with physical handicaps, particularly with sensory distubance, crippling orthopedic conditions, cardiac and respiratory irregularities, neurological defects, and deficiencies in motor coordination and muscle tone. Any or all of these defects may substantially impair a retarded child's social adaptation and also deprive him of opportunities for intellectual stimulation. Yet often we judge the rehabilitation potential of retarded persons without first making a determined effort to alleviate such physical handicaps through medical intervention and thereby bring about improvement in the person's general ability to function.

Too frequently a diagnosis of a child's condition is automatically read as a prognosis instead of merely as an assessment at a given time under given circumstances that is subject to change with time or under changed conditions such as increased stimulation or therapeutic or educational intervention. The confusion between diagnosis and prognosis leads to a vicious cycle: when a mentally retarded person is regarded as unable to learn a certain task, he is excluded from training programs and thus deprived of an opportunity to prove himself, and his subsequent very poor performance is then regarded as bearing out the initial low estimation of his capacity.

Nevertheless, retarded persons have made remarkable progress in general functioning in spite of initial low test performance when vigorous steps have been undertaken to ameliorate adverse conditions in their lives and to subject them to appropriate schooling or vocational and social training.

While in isolated instances some excellent work has been done in this country, the major work in demonstrating the rehabilitative potential of seriously retarded persons has been done in England. Since 1955, Alan and Ann Clarke, Beate Hermilin, Neil O'Connor, Jack Tizard, and Herbert Gunsburg have been reporting in the professional literature the results of studies that clearly show how badly the capacity of persons with IQ's under 50 have been underestimated.[3–6]

Again, with outstanding exceptions, we in this country have been rather slow to emulate the pattern set in England in developing work training for the seriously retarded or even to recognize adequately in our professional literature the significance of the findings of research done there. In fact, professional workers often seem to react with hostile resentment when confronted with information regrading the vocational and social achievements of severely retarded persons.

AN ILLUSTRATION

At this point, it seems pertinent to summarize the case of a young worker in an industrial training unit that is part of the mental retardation facilities in the city of Oxford, England. The case is presented in more deail in an article by Paul Williams in the *Journal of Mental Subnormality*.[7]

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[3] Clarke, Ann M.; Clarke, A. D. B.: Mental deficiency—the changing outlook. Methuen & Co., Ltd., London, England. 1958. (Second edition, 1965.)

[4] Clarke, A. D. B.; Hermilin, B. F.: Adult imbeciles: Their abilities and trainability. *Lancet*, August 13, 1955.

[5] O'Conner, N.; Tizard, J.: The social problem of mental deficiency. Pergamon Press, New York. 1956.

[6] Gunzburg, H.: Social rehabilitation of the subnormal. Bailliere, Tindall & Cox, London, England. 1960.

[7] Williams, Paul: Industrial training and remunerative employment of the profoundly retarded. *Journal of Mental Subnormality*, June 1967.

This young man, John, is today 18 years of age. He is an only child, whose mother, a teacher, was 44 years old when he was born.

John's early childhood was uneventful. At age 2, he started to talk and could say a number of words distinctly. However, by the time he was 5, he was clearly severely retarded, and so he was placed in a local training center similar to our classes on the "trainable" level. At that time, he scored a social age of about 18 months on the Vineland Scale. In the following year, at age 6, he failed to score on the revised Stanford-Binet intelligence test and, again, scored a social age of less than 2 years on the Vineland Scale. He was away from school a great deal because of illness, and while he was ill he stopped talking altogether. He has had no recognizable speech since.

During the ensuing years until he was 15 years old, John remained in the lowest class at the training center, a class that caters to the "babies"—preschool aged children—as well as to older children who are very severely handicapped with both physical and mental deficiencies.

This is a good example of a practice (common in this country as well as in England) that is purely for the convenience of the staff and administration and does not take into account the major needs of the children involved. Severely physically handicapped retarded children are a particular "bother" and therefore all too often are left with the lowest ability group even when they have a greater degree of intellectual ability and could profit from stimulation of more intelligent children.

When John was 15, he was admitted for a temporary stay to a newly opened junior hostel for retarded children and adolescents in Oxford so that his mother could have a brief vacation. This type of institution represents an important new kind of service in England that is rarely found here. To the great surprise of everybody, John adjusted well to the hostel and made definite improvement in his ability for self-help. When the time came for him to return home, the staff suggested that it might be well if he could stay at the hostel for 5 days each week and spend his weekends in his mother's home.

This arrangement was made, and as a consequence John improved a great deal in his general functioning. Nevertheless, 6 months after his admission to the hostel, his rating on the Vineland Scale was only 2 years 2 months. On the Minnesota Preschool Scale, form A, he passed only one item, showing a nonverbal mental age of approximately 2 years and a verbal mental age of less than 18 months. He still had no speech.

Here, then, was a young man with mental retardation about as severe as one is likely to see in the community, who had had the benefit of a "training center" for 10 years, and whose advance during all those years was so minute as to suggest a dour prognosis. Nevertheless, when a new industrial training unit for the mentally handicapped was started in Oxford, the director of the hostel strongly urged that John be admitted to it. Naturally, the training unit received this suggestion with much skepticism, but, nevertheless admitted John for a trial period.

For the first 2 days the manager of the industrial training unit spent a great deal of time working directly with John. In the beginning he had to hold John's hands and force the action required for the simple task he was to do—stripping some plastic material from the product. After a while John began to dislike being held, and he began to work independently. After 3 weeks he had fully mastered the task and could be placed at a work table with other trainees. He thus became a member of the working group.

I cannot go into all the details of John's growing adjustment, but I will describe briefly his subsequent work performance. During a typical morning's work, he sorted pieces of plastic of two shapes but of the same color and of about the same size. He worked slowly but steadily. During one half-hour period he sorted 700 items without making a single mistake. He also demonstrated that he remembered and could take up again without error a working procedure that had been taught to him 2 to 3 months earlier but that he had not been engaged in for some time. He also showed an ability to identify and correct mistakes that he made in his work and to react appropriately when two boxes in which he was placing parts were switched—he would switch his hand movements in order to continue to put the right part into the right box.

John still scores a nonverbal mental age of between 2 and 2½ years on tests. He still has no recognizable speech but can understand simple commands, and he recognizes his own name. However, his placement in the hostel has made it possible to involve him not only in a work program but also in a program of recreation and social activities, an opportunity he never had before.

It is often said that we should not push persons of such extremely low intellectual capacity into work—that this is a cruel and unethical procedure. Yet all the evidence seems to point to work performance as the factor that stimulates such persons sufficiently to enable them to participate in and enjoy group recreation programs and other pursuits.

I have purposely chosen an illustration from the lower levels of mental retardation because it seems to me that we have, at this time, more to learn from the lower levels that we can apply to the upper levels than the other way around. But, certainly, I am aware that quantitatively the bulk of our work must be directed toward the less severely retarded, a vastly larger group of persons.

AN EYE TO THE INDIVIDUAL

It seems obvious that we have been far too much influenced by prejudicial generalizations about the expected learning capacity of mentally retarded persons as a whole and have let these generalizations stand in the way of efforts to help each retarded child and adult reach toward his highest possible level of life fulfillment at home, at work, and at play.

One of the most significant areas of recent exploration in the field of mental retardation deals with the development of the self-concept in mentally retarded children, regardless of the degree of their handicap.[8,9] Further studies are needed to find out how the retarded person sees himself among his classmates or his colleagues in a workshop, whether less or more severely handicapped or nonhandicapped; how he sees persons who teach him or work with him; and how this relates to how the workers see him. For example, what does it mean to a retarded adolescent to be treated in school like a little child, singing nursery rhymes and playing "silly" games although after school hours he joins the rough life of the city streets?

Studies are needed to show the problems arising from the different kinds of worlds confronting the retarded—the world of home, the world of school, the world of the street and community, the world of work—and their often so different levels of language, feeling tone, and expectations.

Research is also needed to develop criteria for making an adequate quantitative assessment of capacity for and performance in adaptive behavior. And such scales must be tested in day-to-day practice to provide an operational basis for the presently accepted definition of mental retardation.

Above all, developmentally appropriate activities need to be provided for the mentally retarded for all aspects of life at every stage of life.

* * * the Welfare poor have managed to hide themselves behind our image of them as defectives. They have consented to think of themselves as "multiproblem" or "culturally deprived" because they are not so secure in their dependencies that they wish to cause trouble. Besides, they are not fools. They see that their families *are* often likely to be in a turmoil and that their children are often doomed to certain pathologies. Why should one expect them to be otherwise? But what is appalling is how they have been cajoled into seeing all their problems as arising from every conceivable factor except inadequate public services and deprived economic conditions . . . .

Richard M. Elman, "The Poorhouse State," *Pantheon Books, New York, 1966.*

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[8] Cobb, Henry: Self-concept of the mentally retarded. *Rehabilitation Record,* May-June 1961.

[9] Edgerton, Robert B.: The cloak of competence; stigma in the lives of the mentally retarded. University of California Press, Berkeley. 1967.

CHRONOLOGY OF SOME OF THE EFFORTS OF THE D.C. ASSOCIATION FOR RETARDED CHILDREN, INC. (FORMERLY HELP FOR RETARDED CHILDREN), 3422 OLIVER STREET, N.W., WASHINGTON, D.C. 20015

JANUARY 19, 1972.

To: Health Planning and Advisory Committee, Sub-Committee on Developmental Disabilities.

The following comments, questions and observations have resulted from several days of concentrated study of mountains of papers in an effort to determine if my goals for achieving publicly funded programs for the handicapped can be realized through this committee. Some papers were from the old Mental Retardation Coordinating and Planning Committee which had its first meeting in 1964 and issued its final report in 1969. Not one recommendation that I can determine has come to pass from this Plan. The other papers I studied were those of this Developmental Disabilities Sub-Committee, the replacement for the old Mental Retardation Committee.

Comments and observations ensue not only from participation in the above-mentioned committees but also from my own experiences as a consumer of services, having a 14 year old retarded son, and from my activist work with the D.C. Association for Retarded Children (formerly Help for Retarded Children) as a member of the Governmental Affairs Committee on their Board, and with Concerned Citizens for Exceptional Children. This work has put me in contact with hundreds of parents, rich, poor, black, white, educated and uneducated. I have also met and worked with many professionals.

I realize that as a consumer, I am a very important component of this Committee, perhaps one of its most important components. The culmination of my experiences to this date, lead me to say that where programs for the handicapped in this city are concerned those of real consequence and existing long before all this federal money began floating around, are the private agencies, financed by private funds, often religiously based. When the chips are down, it is these agencies, some subsidized also by UGF funds and tuition, who are easing the anxieties of parents for programs. The only thing wrong with them is that if they cannot be afforded financially, many children go without proper education and training. Even those of us who can make them available to our children, many of us at great sacrifices, cannot stand the strain of life-long tuition, medical, dental and sometimes psychiatric expenses, all of which can be extensive in some cases. Programs for the handicapped must be FREE so that EVERY child is taken care of!

We require no surveys to tell us of the needs. We already know that thousands of children and adults who are educable mentally retarded, especially those with multiple handicaps and emotional overlays, are not receiving an education or training in this city. We know that epileptic children and adults are without education and training programs. We know that whole areas like Southeast are without facilities of any kind. We know that the Mental Health Centers have faltered in the services they were set up to deliver, certainly they do not seem to be serving the retarded to any large extent. What are the mental health centers doing? Could someone tell me where their funding comes from? Is it from this Act? Is this Committee in any way connected to those centers?

I highly resent that the city departments of the District of Columbia are also the State Planning officials of Federal Funds. We need a planning office completely removed from the District Government to dispense and evaluate the use of federal funds. The city government, beset with many seemingly insoluable problems of budget and administration, cannot deliver the goods fast enough or cheaply enough. I suggest that we can get the most out of the money in this ACT and other federal funds, by contracting the know-how of existing private agencies.

I also regret the confusion of ACTS and monies arising from the necessity of the Federal Government to intervene in the care and education of the handicapped. This intervention is a direct result of the undeniable lack of human sensitivity to the needs of the handicapped at the local levels of our governments all over this land. I regret the inability of the District of Columbia, in particular, to best use those federal funds available to them. I understand that the District in 1970 had 15 grants from HEW in the area of retardation involving $1,133,348. Who got this money and how many children are getting what kinds of services? Certainly the survey did not include this kind of information, which is necessary to have.

It has been my proven experience that the only force capable of getting programs off of paper and out of committees is parent pressure.

I am disappointed that this committee has not yet forthrightly developed a united plan of action that can unfold over the years, to service—areawise—those priority needs in priority areas. Set up any type of facility—day school, day care, emergency care unit, sheltered workshop, and see it bulge at the seams as soon as word gets around it exists. No one can deny that a center comparable to the services being given by the Occupational Training Center or by the Kennedy Institute is needed NOW in the southeast. No one can deny that if you had facilities, areawise, to take all of those educable mentally retarded children referred from the D.C. Recreation preschool program and from diagnostic clinics like Howard, Gales, Georgetown, this would not constitute the filling of a tremendous need for those young and older children now regressing in the school system and dropping out of the school system. With per pupil *normal* expenditure from the schools, money from this ACT, plus matching money from the city government or directly from Congress, we could deliver an educational and training program for many children. We can't wait forever for the public school system or the Department of Human Resources. Privately contracted, publicly funded satellites of services in every area of our city are the only way to keep programs responsive to individual needs. Government-run programs are too slow—too costly—too late—and not responsive to people's needs.

Finally, I urge this Committee to initiate and pursue MANDATORY medical, and other diagnostic assessments where indicated, for every child in our city, to start at the best age decided upon by professionals in early child development. Pursuing this further, all those children found to be handicapped, be provided a MANDATED program of education and training commensurate with their needs and beginning at a very early age, life-long in scope if need be. Without this mandated testing, we will and can never be sure how much of our population is in need of special services and what kinds of special services must be mandated and budgeted for in order to serve them.

ROSALIE IADAROLA,
Member of Sub-Committee.

HELP FOR RETARDED CHILDREN, INC.,
Washington, D.C., February 16, 1971.

In reply refer to: Robert L. Bostick, 1428 Whittier St., N.W., Washington, D.C., 426, 5870.

Re Fiscal year 72 School Budget and Retarded Children.

D.C. CITY COUNCIL,
District Building,
Washington, D.C.

DEAR COUNCIL MEMBERS: Help for Retarded Children is the District Chapter of the National Association of Retarded Children. We speak on behalf of all those retardates in our city waiting for the help only we can give them. What really counts for must retarded children and young adults, is a sustained school placement, with teachers who care and work patiently year in and year out to train each child's potentials to the maximum. With this kind of attention, beginning early in life, you would be surprised how well 4 out of 5 of these children function in our society.

In our letter and accompanying fact sheet sent to each of you earlier this week, we detailed the needs of 467 retarded children waiting for special placement and 103 children waiting for tuition. At this point may we correct the inadvertent use of the word "disrupting" in our third paragraph of the fact sheet, relative to those retarded children in regular classrooms and waiting for special placement. What we meant to denote was that when these children are in regular classrooms, it is frustrating to all involved—the teacher untrained to meet their special needs, the children capable of learning at normal rates, and the retarded who too often languish in this setting. Anyone who has had contact with these retarded children knows they are mild-mannered, loving and trusting.

The $1,812,000 added funds for special education in Alternative 1 do not even allow for 1 aide to each special class, but instead provide 1 aide to every 10 teachers. Several years ago, the Board of Education established a ratio of 8 children to 1 teacher for trainable retarded classes, and the lack of funds has slowly inched this ratio up to 10 and 12 to 1. Have you ever pictured yourself alone in charge of 12 retarded children—all needing individual attention, all needing constant supervision from the minute they discharge from the bus for school to the minute they board for home? The teacher has only one body with two hands. She eats lunch with her children and cannot leave them even for a trip to the ladies' room. We plead that you add an additional $1,563,000 for 252 aides for the classes set up in Alternative 1 for the retarded.

If this City and the Congress of the United States could match the Board's deepening awareness to the needs of the handicapped, they would fund special education under Alternative 11. In contrast to the starvation rates that special education has been operating at for years, the $5,611,000 increase requested may seem like pie in the sky but it absolutely is not. This funding would allow one teacher aide for each special class—essential for successful operation. It would also allow all children requiring varying approaches of special education to benefit after long neglect of their needs. It is the very least this city can do for some of its children who have been waiting too long for their chance at a share of the "good life." What words can we use to impress upon you the importance of this school placement and special support to the entire lifetime of the children involved? How can we impress upon you the benefits accrued to the whole family structure, to a smoother operation of each school? How the entire city benefits? Right now we taxpayers are paying $5,000 a year for each retarded child housed at Forest Haven in Laurel, Maryland. If these children could have had the services we are pleading for today, 80% of them, according to nationwide statistics, would be able to become taxpaying citizens. Incidentally, this $5,000 represents twice the cost that we are asking now to educate each child in the public school. What we are asking for makes good business sense.

The Mayor and the Council must make a total commitment to all the children in our city by searching for funds in the over-all budget that could be redirected and utilized for them, reviewing tax possibilities, holding out and fighting for a larger revenue from Congress. Our organization will do its share to prod Congress and we urge all citizens to do the same. The future of the District lies in what we do for our children today and if it's money we need then we must all be willing to "chip in."

We ask that the Council hold out for the $155 million dollars requested by the school system, which is a minimum "hold the line budget." We also ask the Council and the Mayor of this city to locate the funds for Alternative 11 of the Special Education part of the 1972 school budget.

This city can afford to do no less.

ROZALIE ISADAROLA,
Co-chairman, Governmental Affairs Committee.

HELP FOR RETARDED CHILDREN, INC.,
Washington, D.C., February 3, 1971.

In Reply Refer to: Robert L. Bostick, 1428 Whittier St., N.W., Washington, D.C.
To Members of the Board and the Superintendent of Schools.
Re Revised fiscal year 1972 Budget.

BOARD OF EDUCATION
D.C. Public Schools,
Washington, D.C.

My name is John Hazel and I represent Help for Retarded Children, the District Chapter of the National Association. We wish to express gratitude to the Board and the School Administration for rectifying deficits in the 1972 budget brought to their attention by our presentation of November 23, relative to training those mentally retarded children on waiting lists for special placement. We are prepared to do battle for the retention of these funds and all budget funds for the school system, at the Mayor's level and the Congressional level.

We are pleased to note the addition of a vocational teacher and a physical education teacher for Pierce School. This school was meant to be a vocational training center for the trainable retarded of Junior High School level. At a recent meeting of the Planning and Coordinating Committee on Mental Retardation, sponsored by the Department of Human Resources, the Department of Vocational Rehabilitation described its services to those present. One of its functions is to act as liaison between the public school and the community and to match, on a one to one basis, those vocationally trained handicapped students to a specific job and employer. The children of job placement age at Pierce School could not benefit from this service because the Department of Vocational Rehabilitation can only negotiate, by law, with those facilities engaged in vocational training of the handicapped. Although Pierce school has been functioning for over two years, it cannot yet meet this requirement. We urge the Board to insist upon a positive course of vocational instruction at Pierce that will end in a cooperative working arrangement with the Department of Vocational Rehabilitation.

We return, as we have for the past five years, to a most pressing matter which is not addressed to in this budget, nor has this matter been addressed to in any budget since 1967—that is the urgent need for special classes for those educable mentally retarded children not making it in the mainstream and needing more than what is offered in classes for the trainable retarded. We are aware that due to an absence of these classes, educable mentally retarded children are being referred by Pupil Personnel Services to trainable classes and this is just as undesirable as what was happening in the basic track. Help for Retarded Children holds the Division of Instructional Services and its arm, the Department of Pupil Personnel Services, responsible for the composition of all special classes. Help for Retarded Children, holds the Board of Education and the School Administration responsible for the fate of those educable mentally retarded children misplaced in our school system. We urge you to end five years of indecision and experimentation with these children's lives by setting up the smaller classes necessary for a developmental curriculum, combined with vocational training leading to job placement through the cooperation of the Department of Vocational Rehabilitation.

Much direction could be given towards the solution of this pressing problem and other special education needs, if the Board and the School Administration would act to use the 1970 funds appropriated for an Assistant Superintendent of Special Education. We have waited long enough to see this position filled and ask your assurance that it will be filled with all possible haste.

We are encouraged that the Board and the School Administration are growing in their awareness of the fact that educating the handicapped student can only add to the strength of the entire school system. We are hoping that awareness leads to the continuation of concrete action.

ROSALIE IADAROLA,
Governmental Affairs Committee.

December 1, 1971.

STATEMENT BY D.C. ASSOC. FOR RETARDED CHILDREN, INC. (FORMERLY KNOWN AS HELP FOR RETARDED CHILDREN, INC.)

To D.C. Board of Education on the "Needs of Exceptional Children in the District of Columbia."

DEAR MEMBERS OF THE BOARD:

My name is Rosalie Iadarola and I am co-chairman of the Governmental Affairs Committee of the District of Columbia Association for Retarded Children, Inc., formerly known as Help for Retarded Children.

We are prefacing our main remarks with the hope that the contents of this evening's meeting and its important consequences on the lives of children will somehow be brought to the attention of the newly elected board members—all of whom we hope are in the audience tonight. We ask that the chairman of the special education committee, Mrs. Alexander, be kind enough to take on this responsibility.

The facts presented to you in the Superintendent's report of October 19, 1971, titled "Needs of Exceptional Children in the District of Columbia", should be nothing new to the Board. These facts have been presented to you, to the City Council, to the Congress and to other city and federal agencies time and again by various parents and organizations working for the needs of the exceptional child—and with ever increasing fervor and pressure during the past four years. The important difference this time is that acknowledgement of the full-blown facts comes from the level of our Superintendent of Schools.

Implementation of the report can only be attained through your total commitment to ACT upon its recommendations NOW.

Despite the reported proposed cuts in the FY 72 budget, one of which was special education, we urge the Board and the Administration to aggressively seek not only restoration of the possible cut but to seek, undeterred, the supplemental and future funds require to proceed with the recommendations of this report. Past and present community urgings, both lay and professional, have culminated in this report and in this meeting. If the Board is not finally filled with the conviction that positive, united, forceful steps are necessary for its implementation, then the needs of thousands of children and the work of hundreds of people will have been frustrated for years to come. Your action, based on total conviction of the documented needs, can be a powerful and contagious mover of men. Our organization has already sent telegrams to both the House and Senate chairmen of the D.C. Appropriation Subcommittees, protesting strongly the proposed cut in FY 72 special education funds. We urge every one here tonight to do the same thing immediately so that protests will get to the Chairmen prior to joint conference on the budget.

We must mention here than in looking over the preliminary 1973 budget for special education, we cannot understand why Alternative I does not start where Alternative II begins. It is incomprehensible that Alternative I does not even ask for funds to wipe out the present waiting list, which can only increase by 1973—unless the Board is so certain it will get the $4,199,000 in its supplemental request. It should also be noted that this budget appears to show the Mamie D. Lee School running at full capacity of 200 children when in fact only 84 pupils are attending school at last check. While on the subject of the Mamie D. Lee school, we must insist on the hiring of the most forward-looking, innovative and creative administrator in the field of special education for a principal. This school was built as a model for the nation and it must have the leadership that will make it the focal point for changing patterns in the education of the retarded in the District of Columbia and nationwide.

Since details on every facet of this report have been presented to you for many years, we have chosen a few highlights to comment on:

a) It's a good report—truthful and thoughtfully comprehensive in its scope. b) Regarding early childhood intervention programs, the public school must be the initiator and coordinator of early education in this city and although the budget cannot absolve a present waiting list for school-age children, nevertheless, the Board and the Administration must reflect its acceptance of their role through its budget requests. c) As the District Chapter of the National Association for Retarded Children, Long demanding proper education and vocational training of the educable mentally retarded child; questioning the efficacy of the MIND program in relation to this child; we are more than just interested in the changes planned for the MIND program as mentioned in the report. We would like to hear directly from the Associate Superintendent of Special Education, what these changes would be. d) We have often wondered how thorough and exhaustive a job of recruitment the Department of Personnel does in view of a scarcity of trained personnel in the field of special education. The Board must insist on an intensive, intelligent, nation-wide approach to recruitment in order to meet the objectives of this report.

In conclusion we say to the Board: It is time to order your own budget department to give special education its long-awaited place in the budget and that a total fight be waged by the Board and the Administration for funds to do a professional job. Let this be the last report on special education—let it be the report to end ignorance and apathy. It is time for ACTION. The Board has a mandate to pursue those funds that may have been cut in the FY 72 budget, plus any supplemental and future funds. The Board has a mandate not to accept defeat regardless of its source. Parents and the organized citizenry will be happy to support your moves and help with the removal of any obstacles. Keep us intelligently informed and we can be most effective—we are the best allies you have because most of us are motivated by the needs of our children. The citizenry has more than proven its concern for exceptional children in this city—the next move is yours.

ROSALIE IADAROLA,
Co-Chairman, Governmental Affairs Committee.

Meeting of May 20, 1970.

To The Mayor's Committee on Mental Retardation Planning.
From Member of Committee, Rosalie Iadarola, Parent and Bd. Member of Help for Retarded Children, Inc.
Re Priority statements from committee members.

If 3% of the total population is retarded, according to the National Association for Retarded Children and the President's Committee on Mental Retardation, and the largest percentage comprises educable retardates, then out of an enrolled population of 150,000 children (expected to rise to 152 or 153 thousand next school year), we can expect to find 5,000 retarded children in the District schools. If the incidence of retardation in inner cities *begins* at 7% then this figure becomes 10,500 children. Mind you, we are talking about CHILDREN not figures.

Pursuing this further—if approximately 1% constitutes trainable children, taking the conservative figure of 5,000, then these children number around 500. They are now being taken care of in Severely Mentally Retarded classes and some are in private schools. This title of Severely Mentally Retarded *must* not be the name used for this program—these children are *trainable. This request is a priority*!

Where are the other 4,500 children who constitute the Educable retardate in the main?

They are in regular classrooms and about 200 of them are in area private schools and despite the claim by the Public School system that there are no mentally retarded children in the MIND (Meeting Individual Needs Daily) program, some of them *are* in the MIND program. Let the public school's department of pupil personnel services *prove* they are not.

Taking this 5,000 figure from the larger percentage figure of 10,500, you have a remainder of 5,500 and we shall assume these constitute mainly the functionally retarded child. Approximately 2,400 of these children are in the MIND program, leaving approximately 3,000 in regular classrooms or out on the street, or at home, waiting for MIND placement.

These children are the cause of despair, frustration, consternation, deep compassion and concern of parents, people at Child Development centers and testing clinics like Howard University, Gales Clinic, Area C, B mental health centers, D.C. Children's, Help for Retarded Children; of teachers, counselors, principals, and psychologists. The private schools in the area get calls constantly from these people for placement and THERE IS NO ROOM. If they can be squeezed in, then the tortures of red tape begin for getting a tuition grant.

The greatest priorities existing in the District of Columbia in relation to the needs of the Retarded children within its borders are:

1. Immediate, expert diagnostic prescriptive identification of the entire school population and District population, to be done by an agency or facility outside the public school. This process should continue for the school-life of the individual.
2. Translation of this, up until now, elusive, garbled, inexpertly determined information into proper programs and facilities—mainly public school.

P.S. The public school must stop denying the existence and the needs of the educable mentally retarded child in the District of Columbia. Pressure has forced them to set up a nebulous program called Transitional Classes—all of four of them—servicing at the most, 60 children. This program is for that child doing better than expected in the SMR group and that child not progressing in the MIND program. It is under the supervision of the SMR program.

WHO ARE THESE CHILDREN? WHAT ARE THEIR NEEDS? Are they retarded? Are they neurologically impaired? hearing imparied? visually impaired? emotionally disturbed? disadvantaged? one or all? Do they constitute the balance of the 3% or 7% figure?

No one in an official capacity in the Public School system has had the courage to admit the gravity of the need and there are many reasons for this, reasons we can go into if you wish to.

STATEMENT BY HELP FOR RETARDED CHILDREN, INC. BEFORE THE D.C. BOARD OF EDUCATION—FISCAL 1972 DISTRICT SCHOOL BUDGET: NOVEMBER 16, 1970

Quote: From page 17-H-23, District of Columbia Public School Budget (fisca year 1972):

"*Special Education.*—The budget plan for FY 1972, except for mandatory costs, requires no increases. The current level of funding is deemed adequate. An effort is contemplated to provide within the system, those services now being provided in out of town facilities through the tuition grant program."

In view of the indisputable facts that: (1) there are now some 340 trainable mentally retarded children and nearly 200 children with learning disabilities tested and identified by your own Pupil Personnel Department as needing classroom space and special teachers now—and God knows how many emotionally disturbed youngsters with the same needs; (2) this Board is in violation of its own standards of pupil teacher ratio of 8 to 1 by permitting existing classes to exceed this ratio by upwards of 15%; (3) inadequate speech and hearing services exist; (4) there are no facilities for the educable mentally retarded child and we could go on and on and on—Help for Retarded Children would like to know, in the name of common sense, who is responsible for making this ridiculous statement!

This Board and this administration can rest assured that the Congress of the United States will be apprised of this erroneous statement.

It is an affront to those of us who have put in thousands of volunteer manhours to obtain services and facilities for these oft forgotten children who are entitled to equal educational opportunities and it is a crime to those youngsters who are being neglected.

This 1972 budget like the 1971 budget, offer not a single additional teacher or classroom for special education. How then do you square this fact with your statement on page 17–H–4 under (quote) "Instructional Goals—#3; To provide children the opportunity for meaningful participation in public education regardless of their handicaps; physical, mental or emotional." (end of quote)

We have nothing further to say.

ROBERT L. BOSTICK,
ROSALIE IADAROLA,
Cochairmen, Governmental Affairs Committee.

STATEMENT OF HELP FOR RETARDED CHILDREN, INC. BEFORE THE D.C. SUBCOMMITTEE OF THE SENATE APPROPRIATIONS COMMITTEE ON THE FISCAL YEAR 1970 BUDGET, JULY 16, 1969

Mr. Chairman and members of the committee, I am Robert L. Bostick and I represent Help for Retarded Children, Inc., the District of Columbia Chapter of the National Association for Retarded Children.

For the first time in years, the handicapped childen in the D.C. public schools are receiving a substantial measure of attention in the D.C. school budget. The requested budget increase for special education now before you includes funds for launching the first full-fledged department of special education in the history of the D.C. public schools—a long-overdue organizational step taken by the school board last year in response to community demand and in implementation of a major recommendation by the Passow Report.

The requested increase herein also provides a long-needed staff increase (including 92 teachers, 70 teacher's aides, and 21 additional bus personnel) for the programs serving handicapped children. This will help cope with a large backlog of unmet needs and with the increased enrollment expected from children hurt by the rubella epidemic of the early 1960s, who are now reaching school age.

However, this requested budget increase of $1,885,737 does not meet the full need, and indeed has been slashed by about 40 percent from the original increase request of $3,147,896 presented by the D.C. School Board. These cuts severely crippled the expansion of the special education program which has been so direly needed for so many years.

We particularly urge that the $100,000 increase now recommended for tuition grants be raised to the $600,000 increase originally requested by the D.C. Board of Education. The tuition grant program provides tuition payments for private schooling of mentally retarded and other handicapped children who cannot be adequately served by the D.C. public school program. The grants are made in recognition of the obligation of the community to help provide for the education of every child, including those from families who pay taxes but cannot benefit from the public schools because the schools cannot educate their children. Through improvement and expansion of their own programs and facilities, the public schools can eventually serve the vast majority of these children.

We also urge this committee to restore the requested funds of $96,757 for the Developmental Center for Special Education in the D.C. schools. This Center enables the school system to study new developments in education of handicapped children, foster research, and provide teacher training. The District funds would provide a companion contribution to Federal funds now available for the Center.

Summing up then, we strongly urge you to authorize the full increase of

$3,147,896 requested by the school board for the special education program in Fiscal 1970—thus placing the total budget at $6.3 million, compared with $3.2 million in Fiscal 1969.

We also add our voice to those of all others interested in public school education in the demand that your full support be given the space expansion program of the D.C. public school system. The outrageous shortage of classrooms bears especially heavily on handicapped children. In space-short Southeast Washington, for example, there are no public school classes for severely mentally retarded children, and in other parts of the city, these classes are seriously overcrowded.

Finally, we request your support for an increase of $94,000 for the mental health and mental retardation program at the new Area C Community Mental Health Center to be established in Southeast Washington by the D.C. Public Health Department; plus the full request for additional staff and funds to serve the rising number of severely handicapped retardates at the District Training School operated by the D.C. Welfare Department at Laurel, Maryland.

Mention of Laurel brings us to this parting observation. Many of the retardates now institutionalized at Laurel at major public expense could be leading productive lives today if they had received proper attention in their early years from this community, its leaders, and the Congress. We ask you to support these programs for training the handicapped child today in order to avoid his becoming a public charge tomorrow.

AUGUST 21, 1968.

To Dr. Benjamin Alexander, Member of Bd. of Education, 2522 S. Dakota Ave., N.E., Washington, D.C.

From Help for Retarded Children and Concerned Citizens for Exceptional Children.

Our organizations and the children they represent, want to thank you for the particular role you played in taking the decisive *first*, necessary step towards the attainment of proper and comprehensive education for all handicapped children; mentally, emotionally, and physically. That first step was the formation of a separate department of Special Education, taken by the Board on August 15, 1968.

We are under no delusion that this can be accomplished overnight, but special education, in its totality, had to have a beginning in the District. It will now be possible for the whole area of—*what is special education?*—to be met head on and for the administration to address itself specifically to that question and bring some of the answers to it.

An Assistant Superintendent of sufficient courage, know-how, foresight, and the toughness required to persevere in the attainment of his goals for special education must be found. This job, allotted for in the 1970 budget proposal must be retained in that budget. Applications for the job should be thrown open nationwide, besides citywide, as recommended by the Executive Study Group and many other people interested and eager to see an all vital job accomplished well over the years.

Once again we thank you for your concrete concern. Please be assured that we do not intend to falter in our pursuit of attaining the best possible education for these children and we stand behind you in your endeavors as well.

Sincerely yours,

ROSALIE IADAROLA,
Chairman, Education Subcommittee of HRC.
ROSE PAPER,
Chairman, Concerned Citizens for Exceptional Children.

STATEMENT OF HELP FOR RETARDED CHILDREN, INC. BEFORE THE D.C. BOARD OF EDUCATION HEARINGS ON THE FISCAL YEAR 1970 BUDGET—AUGUST 12, 1968

I am Robert L. Bostick, Co-Chairman of the Government Affairs Committee of Help for Retarded Children, Inc.

This statement relates primarily to the Special Education Activity of the 1970 Public School Budget, with particular emphasis on programs for the mentally retarded.

On the whole, this appears to be a good budget. It contains several items which HRC has recommended. However, we must confess at the outset our utter confusion over the method used by the School's budget staff to project pupil enrollment. For example, this budget projects an enrollment of 438 severely mentally retarded children for fiscal 1970, which are 18 pupils less than the *actual* March 1968 enrollment of 456 pupils. Even a modest increase based on identification of an average of 3 SMR children per month, yields an estimated 513 pupils for the beginning of the 1970 school year. We ask the Board to take a new look at the total pupil enrollment figures included in this budget.

In order to provide continuous educational services and programs essential to the full intellectual and social development of children whose needs are such as to require resources and assistance beyond that normally available within regular classes, we believe the following steps must be taken immediately:

1. The institution of crisis teaching and diagnostic teaching programs as outlined in the report of the Working Party on Special Education and recommended by this Board's Executive Study Group and the Community Council. The crisis teaching program would provide services for children who, because of behavior problems, need attention periodically during the school day but not constantly. The diagnostic teacher would observe and work with children with problems in order to provide an individual *educational prescription* most beneficial to each child. To quote from the Working Party's report: ". . . The emphasis in this program would be on diagnosing and treating educational problems rather than diagnosing medical or psychological problems, which are often not translatable in terms of educational needs."

2. A Department of Special Education, divorced from Pupil Personnel Services, should be created to establish, coordinate, develop, supervise, and maintain those various necessary special classes and programs required as reflected by the diagnostic teaching activities. This department should be established as an active, research, innovative program, integrated with all other aspects of the School System and Community, and not just a receiving station for consultation and referral of special problems. It should exist co-equally with city-wide elementary and secondary programs and should be headed by an administrator of equal rank. Help for Retarded Children, Inc. has petitioned this Board to create a separate Department of Special Education many times during the past few years. The Passow Report, the Executive Study Group and the Community Council also recommend this action.

HRC urges the Board to accept the recommendation of the Executive Study Group to provide special education programs for children from age 3 through 21. We also ask that these programs include meaningful sheltered workshop and/or work study experiences for the older youth.

We particularly endorse the following items in the 1970 Budget:

1. *The increased number of busses, drivers and attendants for handicapped children.*

2. *The pre-school program for handicapped children, including the mentally retarded.*—We agree that if a handicapped child can be detected at an early age and properly treated at that point, his chances of educational success are greatly enhanced and the necessity for expensive remedial work by the schools at a later date is minimized.

3. *Vocational training for the educable mentally retarded.*—This is a new program and the merits of such training have been amply demonstrated in communities throughout the Nation.

4. *Pilot program of education for mentally retarded children, with I.Q's of 30 and below.*—Also a new program. We believe that these children deserve their share of the public school dollar, and that such training now will significantly increase their ability to lead productive lives.

5. *Summer enrichment program for severely mentally retarded.*—In our opinion, the pilot program conducted two years ago at the Richardson School proved the merits of this type of activity and we strongly urge that this item be enlarged to include all SMR children.

6. *Tuition grants for children whose needs are not now being met in the public schools.*—We urge the Board of Education to unequivocally declare that such grants will be made to all children needing them, regardless of type of handicap, until such time as the public schools provide programs and services for them.

7. *Teacher aides.*—We support the principle of one teacher aide for each SMR classroom, as reflected in this budget. We ask the Board to take advantage of new authority granted by the Teachers' Salary Act Amendments of 1968 to prescribe realistic qualifications for teacher aides, so that those persons who are otherwise qualified but may lack 2 years of college credits will not be automatically excluded.

We view with concern the omission from this budget of funds for operation of sheltered workshop classes for the trainable mentally retarded adolescents.

The rationale for this program is no less important than that for the vocational training of the educable mentally retarded, that is, to provide these youths with the necessary vocational instruction and training to allow them to become productive, tax-paying members of the community. We ask that these workshop classes be established in secondary school buildings so that the students can associate with youths closer to their own age levels and may have access to home economics classrooms, office training, and shop teachers and equipment.

We heartily endorse the early morning physical fitness program, but urge that it be administered by another department of the school system, and that funds proposed for this program in the Special Education Department be used instead for the sheltered workshop program. This is not to be confused with a regular physical education program for the mentally retarded, which we think should be strengthened.

We wish to emphasize again the need for a thoroughly sequential speech and hearing therapy program which is so vital to the successful development of our children. Many retarded youngsters receive only a limited amount of these services—some none at all. We urge that a sufficient number of speech and hearing specialists be assigned to this program on a permanent basis.

Again we voice our deep concern over the impasse which continues over acquisition of site for the construction of the model school for severely mentally retarded children. Funds for this school were appropriated by Congress a few years ago and construction was slated to begin almost a year ago. We urge the Board to give immediate attention to this vital project. It is interesting to note that Recommendation V of the Executive Study Group's report on *School Finance and the Budget Process*, if successfully implemented, would eliminate this kind of problem.

Finally, we urge the Board of Education to adopt and order the implementation **of all** the recommendations of the Executive Study Group, which were based on the various working party reports and approved by the Community Council.

ROBERT L. BOSTICK,
Government Affairs Committee.

STATEMENT BY HELP FOR RETARDED CHILDREN, INC., BEFORE THE SENATE SUBCOMMITTEE ON D.C. APPROPRIATIONS MAY 3, 1968

I am Robert L. Bostick, Co-Chairman of the Government Affairs Committee of Help For Retarded Children, Inc. This organization of parents and friends of the mentally retarded, commonly called HRC, is the District of Columbia Chapter of the National Association for Retarded Children.

Once again I wish to express our deep appreciation for the splendid leadership provided by this Congressional Committee during the past few years in providing funds for vitally needed services and programs for the District's mentally retarded children. This is especially true in the area of public school facilities. However, these needs, as do those of all children, continue to grow and we must be prepared to meet them. Studies show that four out of five mental retardates can become useful, taxpaying citizens who hold jobs and contribute to the positive growth of the community, provided they receive the proper education and training.

Therefore, we strongly urge the support of this Committee for the following items in the City's Fiscal 1969 Budget:

In the area of *Education*, we ask restoration of the $2,909,000 item for a prekindergarten program to give a head start in education to children aged three and four (a program which should include the mentally retarded)—approval of the item of $273,600 for a new program to educate some 300 children with perceptual handicaps that impeded their learning—approval of the item of $143,900 for improving bus services for handicapped children who must stay away from school entirely whenever bus or driver is unavailable, as they too often are.

We support, as a needed addition to the Budget, the establishment of 25 additional classes to handle the rising influx of trainable mentally retarded children into the school system, plus a teacher's aide for each class, and enough speech therapists and physical education teachers to effectively service the needs of these children on a continuous basis.

Until the public schools can meet the educational needs of all types of retarded children, we ask that the present system of tuition grants for handicapped children, now available to the blind, deaf and emotionally disturbed, be extended to include individual mentally retarded children and children with special learning disabilities. Estimated cost: $125,000.

We would like to register our deep concern over the impasse which has developed regarding acquisition of part of the property which was to be used to construct the Mamie D. Lee School for trainable mentally retarded youngsters. After years of effort on the part of our organization and other interested citizens, Congress has appropriated all the funds requested for plans and specifications, site, and construction of this school. However, though construction was slated to begin several months ago, not a spade of earth has been turned. It is hoped that this matter can be swiftly resolved.

In the area of *Recreation*, we requested your support for the pre-school and day camp programs ($71,500), as well as for the proposed recreation center for the mentally retarded to replace the existing inadequate Lincoln-Van Ness Center, at a cost of $400,000.

Health.—According to the Mayor's own Budget Report, "Current health services for the District's mentally retarded are inadequate, and many cases nonexistent." Therefore, we ask your approval of funds of $74,900 for the proposed mental retardation program in Area B, and also the $6,080,000 requested for construction of the new Northwest Community Health Center, at Georgia Ave. and W Street, N.W. which will include facilities for the retarded.

In the area of *Welfare*, your support is strongly urged for the Budget items totaling $114,100 for the improvement of staff, services, and facilities at the District Training School for retardates, and for the Budget request of $2,632,000 for construction of two additional buildings to house residents there.

According to U.S. Government estimates, eight per cent of the school population in a city the size of Washington can be expected to be mentally retarded. In Washington, this would amount to some 12,000 youngsters, of all races, creeds, and colors, the largest educational minority in the student body.

We do not ask for special privileges for this 12,000. We simply request that they be given the same type of consideration for their educational needs that is given the normal and the gifted children.

Every American child deserves as his right an educational program that develops his potential to its fullest extent.

Funds to support major improvements in the D.C. schools can be secured. It is your job to authorize the funds for these improvements.

The children are waiting. They look to you for action now—while they are at the peak of their learning capacities, while they are still children.

STATEMENT TO THE DISTRICT CITY COUNCIL ON THE 1970 BUDGET BY HELP FOR RETARDED CHILDREN ASSOCIATION

OCTOBER 2, 1968.

Help for Retarded Children, although primarily represents the needs of the retarded child in the District of Columbia, is concerned with the total educational problems of the city. This is partially true because weaving in and out of classes from the elementary to high school level, are children whose educational needs have never been attended to in a systematic, knowledgably planned approach. Many of these children are educably retarded and need special educational considerations and supportive services. Those children who are trainably retarded have for the past several years been accommodated in special classes.

In 1959, the educably retarded child had special classes which were ordered to become part of the basic track by Dr. Hansen. We have not been able to determine how many children came out of these original educable retarded classes and went into the basic track, nor what educational approach had been taken for their progress. In September 1967, the basic track was abandoned and these children, this past school year have been placed in regular classrooms to sink or swim.

On March 14, 1968, a pilot program called MIND (Meeting Individual Needs Daily) was instituted in a few schools from elementary to high school level. This program was aimed at keeping the children with special needs in regular classrooms but giving them, for reading and arithmetic, a special teacher in a temporary physical environment. For all other subjects they went back to their regular classrooms, once again to either sink or swim. Some are benefiting from this arrangement, some are behaviour problems, some just sit and dream and get promoted. It all depends on one's definition of retardation and special learning disabilities and on the skills of the teachers involved. So we are not far removed from the problems that were evident in some basic track classes.

The key, in our opinion, to unlocking the door to the education of all children with special learning needs is professional, competent and thorough diagnosis and best of all started as early as possible. The District of Columbia must make a concerted effort to provide this particular kind of service NOW to our school children at all levels.

Therefore, we place this diagnostic service highest on our list of priorities for funding throughout the involved agencies.

We ask the Council to be aware of the need for funds in the following areas also:

1. Staff development of teachers, principals, administrators in the education of the needs of the retarded child.
2. In-training courses for teachers now in the system and eager to work in this area of education.
3. All the school buildings we need in order to reduce the pupil teacher ratio all over the District, making it possible to implement the art of teaching.
4. Tuition grant funds until the programs now on paper and in process of implementation get a chance to make some impact.
5. Preschool education.
6. Maintaining and expanding the present classes for the trainable retarded, always keeping the pupil teacher ratio 8 to 1 as prescribed by the Board of Education.
7. Maintaining and expanding vocational classes for the trainable and educably retarded child on the secondary level.
8. Adequate transportation facilities for the trainable and those educably retarded not capable of self transportation.
9. Teacher aides.
10. Supportive services, such as health and welfare, recreation.
11. Fulfilling the needs at Children's Center, in Laurel, Md.
12. Pilot Programs for innovative approaches to educating the very low IQ child to self help.

We parents of the retarded have a dream—that some day in the District of Columbia, the retarded child and all handicapped children will no longer be lost in the educational and political maelstrom existing in our school system and city. That learning needs will be pinpointed and the children will be placed in educational settings that will develop them to their greatest potentials—starting at the age of 3 and going on up to the age when they can be gainfully employed in private and public agencies or in those cases where this is not possible, in sheltered workshops. Perhaps the public schools should not be asked to do the entire job—but does any one have any other suggestions?

We parents and friends of the retarded want the public schools and supportive agencies in Washington to be given the human and physical tools with which to do the job right. We are not specialists but we know that our children need something much more than what they have been getting. We are keeping a close watch over the plans the public school has for our children.

We, in the District, are fighting and struggling for things that many people in the rest of our country take for granted. At this time we ask the Council of this city, our city, *not to be responsible* for any cuts in this budget and in fact to examine closely those cuts already made. Special Education suffers a greater proportional cut (20% roughly) than the total school budget (roughly 18%). We make this request so that all of the children in the District will have a greater opportunity to move in the right direction, educationally. We know you want this too.

(Mrs.) Rosalie Iadarola,
Government Affairs Committee.

FAMILY AND CHILD SERVICES OF WASHINGTON, D.C.,
Washington, D.C., March 9, 1972.

Hon. JOHN L. MCMILLAN,
Chairman, House District Committee, U.S. Capitol, Washington, D.C.

DEAR MR. MCMILLAN: Family and Child Services offers among its programs foster family care for emotionally disturbed children. It is therefore sensitive to their needs and well aware that effective service to the emotionally disturbed requires a variety of services ranging from those which are preventive in nature to aftercare for those who have received intensive therapy in any setting.

The weakest link in this chain in Washington is the lack of public residential treatment for emotionally disturbed children. For children over the age of ten, group residential treatment is completely lacking.

This agency's Family and Children's Service Committee is aware of the proposal advanced by the D.C. Mental Health Association for the establishment of four small residential treatment centers for emotionally disturbed children, one in each Health Area, and heartily endorses the plan.

Very truly yours,

JOHN G. THEBAN,
Executive Director.

COVINGTON & BURLING,
Washington, D.C., March 22, 1972.

Re Proposal by District of Columbia Mental Health Association—Residential Centers for Emotionally Disturbed Children.

Hon. JOHN L. MCMILLAN,
Chairman, District of Columbia Committee,
House of Representatives, Rayburn Office Building,
Washington, D.C.

DEAR CONGRESSMAN MCMILLAN: As a member of the Board of Directors of the Episcopal Center for Children here in Washington, I am writing in support of the statement presented by the District of Columbia Mental Health Association before the District of Columbia Committee on March 14, 1972.

Since 1959, the Episcopal Center for Children has operated a non-sectarian residential facility for 25 emotionally disturbed children, primarily from the Washington metropolitan area. An additional 35 children are enrolled in the Center's day program. The experience of the Center has been that treatment of emotionally disturbed children is less expensive and more productive if they are enrolled at an early age. It is highly encouraging that most of the children who have been treated at the Center are now in high school, college, in military service, or in good jobs. Of course, the Center has limited financial resources and hence is able to accept but a small number of the children in the Washington area whose emotional problems require specialized professional care.

Attached is a short brochure describing a child who might benefit from such residential treatment. Also attached is a copy of a recent speech by Mrs. Elsa Miller, Director of the Center, describing in more detail a portion of the Center's program.

When ligislation is introduced, representatives of the Center would appreciate the opportunity to submit a written statement and perhaps appear before the Committee to express the Center's views on such legislation.

I understand that the record of the Hearing last week has been kept open to permit supplemental comments on the proposals. It is respectfully requested that this letter and the attachments be made a part of that record.

Sincerely yours,

PETER B. ARCHIE.

Attachments:

THE DISADVANTAGED CHILD

The material presented at this time reflects the experience of five years of work with young schoolchildren who suffer from the triple handicap of economic deprivation, cultural disadvantage, and emotional disturbance. These children present a very severe problem in the classroom, and potentially in society as a whole. In many urban centers with large populations of disadvantaged families, the problem is indeed a serious one. It was the magnitude of the problem, and possible the challenge it presented, that led to establishing a unique day school and activity setting in connection with a private residential treatment facility, The Episcopal Center for Children, in Washington, D.C. This was accomplished with the help of funds from Title I of the Elementary and Secondary Education Act, granted through the District of Columbia Board of Education, and has been carried out with the cooperation of the school system. All teachers in this "Special Project" have been teachers from the District of Columbia public school system and the entire plan could aptly be called an adventure in cooperation between a private social agency and a large public school system.

Though this project was originally set up as a demonstration and research center, it is by now functioning as an on-going service, still in cooperation with the public schools. This presentation deals primarily with the program itself and not with the research elements. The focus is the relationship between the child's handicaps and his school performance, and what can be done about it. Roughly, the content divides itself into several parts: (1) who are the children, and what are the problems?; (2) staffing; (3) classroom structure; (4) teaching program; (5) activities outside of the classroom, (6) special activities, and (7) work with the parents.

THE CHILDREN

At the beginning of the program the children selected ranged from a little under six to about eight and a half years. During the last two years, as older children have been phased out, only younger children have been accepted, with the current admission age between four and a half and seven. Boys only are involved in the project, and children who are demonstrably mentally retarded are excluded. The Intelligence range has been from 68 to 102 on the Stanford-Binet at the time of admission. Thirty-five children are in this day program at any given time.

The children have all been referred from schools in the poverty areas of Washington, and are severely deprived. They were considered by their principals. teachers and counselors to be their most disturbed children, and their most difficult to handle or maintain in any kind of classroom. Since we are dealing with schools in areas heavily populated by Negro families, only Negro children have been referred to us. All come from similar environments and economic backgrounds, and about two-thirds of all the children have come from homes without fathers.

The problems presented by the children, as reported by the school, are numerous and severe. The larger number are disruptive, destructive, angry children with little or no self control. However, there have been quite a number of problems, and the following comments from school reports are representative, with many children having a long list of symptoms.

> "Disobedient, responds to no discipline, stubborn, profane, refuses to do any school work, violent anger, destructive."
>
> "Truant and accomplished liar; explosive."
>
> "Difficulty adjusting in a group; unhappy, depressed, confused, withdrawn."
>
> "Disruptive in class; screams loudly and often; very uncooperative, fighter, explosive, a bully."
>
> "Frightened; bizarre behavior and unrelated, confused remarks; frequently not aware of others or what is going on around him. Lives in dream world at times. Thinking disorganized. No relationships with people."
>
> "Anxious, distractible, hyperactive, very short attention span. Lives in imaginery world; does not learn."
>
> "Chronically tense; overly sensitive; cries easily; jittery; nervous; too anxious to do school work."

These are examples of presenting symptoms to give an idea of the range. Many additional symptoms have, of course, been found, including fears and phobias, soiling and wetting, stealing and lying, and feelings of rejection and depression. They have come to us with a great deal of defiance of authority, hostility toward school, and teachers as well as toward the rest of the world, and with such an overwhelming lack of self-confidence—often hidden behind an air of bravado—they have felt utterly defeated in all of their relationships. They all have had in common, very poor school achievement, with three-quarters of them having made no academic progress whatsoever, and in the case of the youngest ones, no semblance of readiness for school. The remaining one-quarter have made only very slight progress. All have stood out as being different from the other children in the class, though almost all in the class have come from similar backgrounds and have suffered similar deprivations, both economically and culturally.

STAFFING

With this diversity of problems—educational, social and behavioral—it is apparent that a large staff, representing several disciplines, is necessary. There are four full time classroom teachers, and part-time music and art teachers; two and ½ psychiatric social workers; one clinical psychologist, one consulting psychiatrist, who also sees the children diagnostically; five counselors (their duties will be clarified later) and the necessary secretarial, domestic, maintenance, and bus driving staff. Neurological and pediatric consultations are available as needed with routine health examinations and innoculations provided through the public school health services. The supervisory and administrative staff of the residential treatment center at first functioned in these capacities for the day program, and still do in part, but by this time some supervisory staff has been developed within the day program itself. The director of the Episcopal Center serves as director of the entire program, both residential and day.

PROGRAM STRUCTURE

The children are picked up by bus at their homes. Breakfast, to eat or not as they choose, is available to all children when they arrive. We do not ask children if they have had breakfast, and most of the children are ready to eat. After breakfast, and a check by the nurse, half go to their classrooms, and the other half to various activities. After an hour, the groups change places. Those who were with a counselor go to their classrooms, and vice-versa. After a noon dinner they all have a play period, after which the morning procedure is repeated. The children leave at 3 o'clock, after having a snack of fruit juice and cookies. The above is a capsule description of the basic "bare bones" structure of a school day.

From our experience with disturbed, non-achieving children, we knew that they would need to be worked with in small groups for relatively short periods and in diversified activities. We also knew that these disadvantaged children in particular had a great deal to learn outside the classroom. We therefore, started out with a system whereby the children would be in the classroom half the time if they could tolerate this and with young men counselors or in other planned activities the other half.

With four full time teachers and thirty-five children each teacher is assigned eight or nine children, but has at the most four or five in her group at any one time. Sometimes she may be down to two children. The system is flexible; there are times when children can't be in the classroom at all, and others when they can't tolerate the entire period and have to be removed by a counselor. No matter how effective a grouping seems to be, it must incorporate flexibility to remain effective, since the children do not all change at the same rate or in the same direction, and individual needs very from day to day, particularly when a child first comes.

TEACHING PROGRAM

These children have a history of nothing but failure as persons as well as students. To help them achieve some small success has to be the first task of the teachers. For it is not until a child has had some success that he can tolerate the challenges that may result in failure at times, but will help him grow. Every child is accepted as he is at that moment, in learning and in behavior. We are not concerned with what he should have been or could have been, but simply with what he is. So all teaching starts at a very simple level, to make some success possible, and very small victories loom very large indeed.

The teachers often find it necessary to devise their own subject matter as they try to capitalize on any interest or background knowledge displayed by the child. Interest in books is built up through actual experiences the child has. On the same table as the incubator where the children breathlessly watch baby chicks hatch, there are books open to scenes similar to the one they are watching. Interest in the books increases in spite of themselves. Whether growing plants from seeds, or finding interesting rocks, or feeding goldfish, or handling a turtle, or picking up pine cones, they have simply written books, or stories composed by the teachers, that tell them about the real live situation they're in. The books are simply there—not forced upon them—but they suddenly become alive and important-possibly even worth trying to learn to read! And for those who haven't reached the point where printed words—or even letters—have any recognizable form, or have not as yet developed an attention span that permits learning the basic elements of reading, pictures without words related to the experience the child is having and stories with puppets, give him an opportunity to express ideas, improve his speech and vocabulary, and begin to develop an interest in words.

Since language skills are so vital in learning, we stress this kind of learning from the very beginning, and the classrooms are filled with more "things" than books, and with a great many pictures and records with which a child can identify and that are conducive to story telling or listening. For listening is a wonderful learning experience, and a new one to most of our children. However, for some children listening comes about first through sounds and rhythms, so such techniques are used. There are great lacks in both visual and auditory discrimination, and the teachers devise many methods of working with these problems.

Some comments from teachers during the year are illuminating in regard to the development of "academic" work, and the preparatory work that must precede it. A few examples will suffice to give an idea of the functioning level academically. These comments are quoted from records:

"He came to us with an attention span of about three seconds, barely able to say his name, unable to walk in the same direction as the class, or to recognize any form, though he was seven years old." After a great deal of play with blocks and puzzles and the "fun" kind of perceptual training, and after learning to listen and articulate, all happening in both the classroom and in activities, an interest in actual school work developed. But this took eight months.

Another seven year old, after six months, has as his greatest accomplishment "learning how to work quietly in a classroom, and to accept the teacher as an authority. There is no more wild, speedy destruction of everything around him. He has learned how it feels to sit quietly in a schoolroom—he is getting ready to learn."

A seven and a half year old, after a full school year, finished his first pre-primer and two work books, but "his greatest progress is in a tremendous growth in curiosity and talking ability."

During the years, the teachers have used many different types of teaching material and text books, searching for those most suitable for our children. Some emerge as being of more value than others, but what seems best for one group or child is not always best for another. But many little things are important to all of the children, and help motivate them and capture their interest and attention. Even such things as the best use of bulletin boards become important! In every classroom the bulletin boards have exactly equal spaces marked off—one for each child—for display of his work. And his name must be there! The importance of something of his own and something with his name on it—really a space to call his own—cannot be over-emphasized—it is one of many small, but highly significant things that one can find in the classrooms. Words printed on many objects or to designate places in the classroom have been very helpful. Large posters with paper cut-outs to illustrate over, under, on top of, beneath, beside, near, far, up, down, etc., are devised by teachers to help the child with certain aspects of his language lacks. Most of the children are unfamiliar with adjectives and adverbs and connectng words, and need concrete illustrations in both pictures and movements. They need to touch, to feel and have spatial experiences for which they will later find words. Needless to say, this all also plays a part in their perceptual training. There is recognition in the class-room of the need for movement with our restless often hyperactive children. But learning can go on if the child is walking around, or stands instead of sits, or learns to count while hopping from one number to the next. But in the last analysis, it is the teachers' creativity and ingenuity, tolerance and patience, and above all the acceptance of every little boy as he is, that has provided the climate of the classroom that has made is possible for the children to begin to utilize all the aids to learning that have been provided for them.

ACTIVITY PROGRAM

The children have a great deal to learn outside the classroom, and at some stages of their development this is the most important part of their learning. The activity program with the counselors has been most effective. This has been where the children have learned to live with one another, and accept discipline, authority, and limitations. This is where many of the ways to build or destroy or evade relationships have been explored. The children have gained important satisfactions in athletics, games, handcrafts, etc., to help them develop good self-concepts and to further the establishment of meaningful relationships. Movies and short trips to many places of interest to the children have been incorporated into the program from time to time—some educational and some just for fun—to broaden the horizons for many of the children. The counselors, young college or graduate students, chosen for their ability to relate to and work with young children, become very important in the lives of the children. Some of the most successful "therapy" takes place on the playing field; a piggyback ride can do wonderful things for a little boy who has never had this experience. Spacious grounds to run on and trees to climb present him with a new world. To have a young man who plays with him, talks to him, and cares about him—who puts some structure, organization and discipline into his life—whom he can depend on to have the same rules tomorrow as he had yesterday—is a wonderful experience for many of our little boys. The counselors have been an indispensable part of the program and play a most important role in the lives of children who often have never known a father.

Music and art have also played a vital role. The children have learned to sing in groups, enjoying it and finding it easier to memorize songs than more prosaic material: They get great pleasure from both listening and performing. Painting and drawing has also been very important, and the walls have been filled with their colorful productions during the year. The painting is at a very immature level, but gives them great satisfaction, and that is what is important. No creative piece of work can be anything but right and good.

Learning to use and enjoy a library is another needed activity. The library is set up exactly as a public library is, and is very well equipped, with books for every interest and reading level. The chldren make good use of it. They learn something about the responsibility as well as the pleasure of borrowing books. Our hope is that many of our children will leave with an interest in using their school and neighborhood libraries.

Workshop is a wonderful experience, not only for developing skills but for giving the children tremendous satisfaction. Children who can attend to classroom work for only very brief or even fleeting periods might work diligently at sanding in order to put a beautiful, smooth finish on a little bench or bookrack. A boy will work like a beaver to build a jewelry box for his mother, or a tool box for his father. He's learning patience and perseverance, and he's learning something about arithmetic as he learns to measure, and about listening to directions and following them if his creations are going to turn out right. He has to learn something about self-control if he's to be able to stay in a workshop full of tools that could become weapons, and while he's building with wood he's also building his ego, and having great fun in the process.

SPECIAL ACTIVITIES

The clinical psychologist plays a very significant role with the children, in a variety of psychological evaluations and educational assessments of specific abilities and disabilities. This is, of course, helpful in the classroom and even on the playground. Psycho-therapy is another important part of the program for many children. Some need such treatment and can profit from it as soon as they come. Others may not be able to profit from treatment until they have been with us for several months. Still others may get all they need from the therapeutic milieu.

PARENT INVOLVEMENT

With a strong conviction that it is difficult to be of lasting help to seriously disturbed children without also working with their parents, we have tried to involve all parents in a casework process. The social workers at first met with resistence or out-right hostility from some families, but this has not persisted very long in most instances. There are variations in the degree of cooperation or of understanding why they need to be involved, but gradually many of our families (or, more usually, mothers) have been able to begin to think in terms of parent-child relationships, their own impact on the child, and ways of improving the atmosphere in the home. Many problems between the parents come to light, and problems of the other children and many of the needs of the family are brought out. Here the social workers are able to help them find the proper agencies to help them. But we do not take over parental responsibility. We offer help and encouragement, and if necessary take them by the hand, but we do not do for them the things we feel they could do for themselves. Many times it would be far easier for the social workers to "take over". But this would not be of lasting help, and would not further the relationship between the child and his family.

The social workers have seen many changes in the parents, and the following quotations give some interesting glimpses into the process:

"There has been increased awareness and increased interest in the child's problems."

"Some parents are beginning to recognize the relationship of parts of the child's behavior to parts of their own behavior."

"Some parents are becoming more aware of their own *rights* as well as responsibilities as parents, and more fundamentally, as people."

"More parents are becoming aware of community programs and services which they can use to meet their own needs."

"A greater number of parents are really involving themselves in a relationship with the social worker."

This kind of relationship—a constructive rather than a dependent one—evolves gradually, and not every parent is able to benefit. Some may never be able to do so, but many are responding.

HOW IT ALL FITS TOGETHER

A disadvantaged child comes into the world with a ready-made environmental handicap waiting for him. He gets wrapped up in it immediately, as though in swaddling clothes, and this is where he stays for far too long a time. He enters into an existence of deprivation, both economically and culturally, with the bleak and barren way of living that comes with utter poverty. One has to wonder if the world doesn't seem like a long, dark and empty tunnel, with no light at the end. Discouragement and despair are the lot of his parents—for them life seems to be a struggle for survival. Somehow these children grow, and finally the time comes when they are ready for school—ready in terms of age, but often far from ready in any other way. Some children have the strength to survive better than others, and they manage to make some kind of adjustment. Some fall by the wayside, unable to cope with the demands and expectations of any society except that of the block in which they live. These are the children who fill up the emptiness inside of themselves with bravado, violence, and anger—or sometimes with a life of fantasy. These are the children who become emotionally disturbed adding another handicap to those they had when they came into the world.

To cope with any one of these handicaps is a difficult problem, but to cope with all of them and give a child a new start in life requires a whole new concept of teaching very broadly defined. We have worked with a team approach, with the team consisting of educator, psychiatrist, psychologist, social worker, counselor and parent, in order to provide a total therapeutic milieu. Our hope is that the child will be ablt to make both a school and social adjustment that will make it possible for him to eventually find his place in the sun. Every child should have that right—perhaps we should have an eleventh commandment, 'Thou shalt find thy place in the sun."

The impact of the child's handicaps on his learning and on his behavior are all too vivid. Consider his immediate environment, where more often than not he has been a part of the struggle for survival. Such struggles are neither gentle nor forbearing, nor conducive to loving one's neighbor. He has lived in chaos and disorganization, and one cannot fail to believe that at least some of this becomes internalized. He has found himself wanting, in every way and on every count, and his self-concept gets lower and lower. Often there is no father in the home, and his mother has so many troubles of her own she may have little to give a child hungry for some response.

With all these problems, how can he learn in school? How can he fit into a group? How can he find order out of chaos? How can he make sense out of symbols, this child who hasn't been read to, who hasn't had crayons and paper to scribble on? How can he follow directions, having never learned to listen? How can he feel any motivation to learn, this child who has no thought of anything good in the future? *Is* there a future? His parents would say, "No". How can he learn to generalize and abstract—so vital in acquiring new learning—this child who has no past to build on and no future to think about? It struck us forcibly one day when we suddenly realized that we had never heard a little boy talk about what he wanted to be when he grew up! We coined a name for our boys—the "now" children—with no yesterdays worth remembering, and no tomorrows to look forward to with joy. For there has been little joy—actually, very little fun—in their lives, and again, every child should have that right. Perhaps a twelfth commandment is in order—"Thou shalt have fun."

So we have many people, and their work must be coordinated, to deal with all these interwoven parts of a child's life. The social worker must bring to the staff her knowledge of what is going on at home so the teachers, the counselors and the therapists can better understand the variables in a child's behavior, and deal with them.

The behavior of the child in school often reflects some problem going on at home, and in the continued contact we have with parents, we quickly learn what has happened. During the year there have been many days when some children suddenly regress, or seem unusually unstable, or are extremely anxious or violent. We try to find out what is happening, so we can help the child with his reaction, and, if possible, help alleviate the situation bringing on the acute behavoir. The social workers are the vital link there, between the school and the home. The families we are working with are faced with so many emergencies, so many breakdowns, actually, and with so many really desperate circumstances, that such a relationship between the school and the home becomes extraordinarily important in the life of the child.

The counselors and teachers must work together and many times activities can be correlated with lesson plans—and each enhances the other. The psychologists' and psychiatrists' findings are vital in the classroom and in one classroom the psychologist and teacher together are having group meetings with the children—reality therapy. And so it goes—with all staff members and the parents contributing to the total picture. Sometimes this kind of team work isn't easy, particularly since it means that at any given time, any one aspect of the child's functioning may be the most important one. For example, there may well be a period when what a child is doing out on the field or in the workshop is contributing much more to his development than the classroom is. This may well be reversed at another time. There would be other periods of time when therapy might be the important thing in his life, or when what is going on at home might be of the greatest significance. What this all suggests is that there is no room for staff rivalries; there is no room for prima donnas; there must be mutual respect; there must, in fact, be team work of the highest order.

No matter what else is going on, however, there are some things that can never be left out of the picture. These are such intangibles as a free and accepting atmosphere, but one with limits and boundaries; warmth and compassion, without superficial sentimentality; affection bestowed and received; trust won and retained; and a feeling of safety and protection as the children reach out to explore new worlds; and last, but far from least, having fun.

We are often asked—does it all do any good? In fact, does it all pay off? The answer is a very firm *Yes*. We do not expect every child to make the kind of progress we would like to see, but all make progress, and most make *good* progress. Of most importance is what happens after they leave. Do they retain their gains? Are they able to maintain themselves successfully in school? Are they learning? Are things better at home? To get the answers we are doing follow-up studies on all children, and we now have two and three year follow-ups. We have lost some children who have moved away, but out of 30 follow-ups with the schools, we have 19 getting along well; 5 who are doing "fairly well", but could be better; 2 who fluctuate—at times they do well and at other times have some problems; and 4 who are not getting along as well as they should but have retained some of their gains. It is of interest and importance that those who are not doing well come from families where we had little if any impact.

CONCLUSION

A way of working with severely disadvantaged and disturbed children has been presented. The years to come will tell the story of its lasting effects, but it looks promising. At least many children have been given a chance and are making a new start in life, with new, good self-concepts and warm feelings toward others. There are no thermometers to measure the warmth of human relationships, but we see it and we feel it, all around us.

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